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ORIGINAL ARTICLES.

THREE OPERATIONS FOR APPENDICITIS, ONE WITH A PECULIAR AND FATAL COMPLICATION.*

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One of the three following cases is of particular and unusual interest and the other two show the danger of delaying operative procedure. I selected these particular three operations as typical of the gravity of the disease, and as showing the importance of early diagnosis and medical and surgical treatment.

The more I see of appendicitis the more I am impressed with the dangers of it, and the necessity of watching the treacherous organ. If the case doesn't show improvement in forty-eight hours, or if it is steadily progressive, undoubtedly surgical interference is demanded. This of course only applies to primary cases; recurrent ones should always be operated on. Fowler says: "The prognosis of appendicitis is unfavorable in proportion to the severity of the infection and in cases treated surgically in proportion to the delay in instituting operative interference." The disease may terminate fatally in thirty-six hours. Cases favorable to medical treatment are those showing improvement in the first twenty-four hours, providing they are not masked by opium. The results,

though, are always uncertain, and even after recovery there is always the dread of recurrence so long as the appendix is retained. The first case which I wish to report was a primary one. I was called to see it after it had existed some days. Mr. R., of Wilmington, had been suffering for days with pain in abdomen, first starting in the umbilical and hypogastric regions, steadily increasing, and, as the pains intensified, locating more and more in the region of the appendix. I might say this patient had been attended by a physician of another school for the first few days of the attack, and consequently I could not obtain a history from him.

I saw the young man the last Saturday in September, 1895, suffering great pain. The abdomen was tympanitic with great tenderness and thickening in the region of the appendix, which I could outline. I was fearful that the case had gone beyond medical aid, but as it was a primary case I concluded to make the effort, taking the precaution to have everything ready for operating at the shortest notice, aseptic room, surgical nurse, etc. By the free use of salines, which I could push, as we had

*Read before Delaware State Medical Society, June 9, 1896.

very little vomiting, and by stopping morphia, he improved in twenty-four hours, and I had the pleasure of seeing my patient apparently well again, remaining well except that he had twinges of pain and continued thickening until February 4, 1896, when he was taken with a sharp attack. Again I strongly advised operation. The patient and his mother were willing, but the father objected; consequently I had to use salines and rest, under which the patient improved but never became fully well, tenderness over the organ continuing. He remained in this condition four weeks and on March 4th was again taken severely. I demanded an operation which was granted March 7th. Before opening the abdominal cavity there was a large semi-soft mass over the appendix. I made the usual oblique incision, and found everything matted together with old adhesions, and consequently had great difficulty in reaching the appendix, which was imbedded in inflammatory tissue and omentum. These I had to ligate and remove with the diseased organ. There was a small amount of pus; the mass was just beginning to degenerate. I used gauze drainage, put the patient to bed and he had an uneventful recovery. To-day he is fully recovered, looking and feeling better than he has for a year. This is a case that should have been operated upon during or after the first attack.

The second case is particularly sad, and to me very interesting. I have not been able to find this complication occurring in any case so far as I could ascertain, consequently I felt constrained to report it. The remarkable complications arose just as I had every reason to be flushed with the prospect of victory and fully expected my patient's recovery. Mrs. M., a young bride of eight weeks, coming to a strange city and among strangers, sent for me the morning of March 17th, giving the following history: The evening of the 16th, which was terribly cold and stormy, she took a walk, wearing low cut shoes with paper soles, thin stockings and no rubbers. At midnight she was taken with pain in the region of the umbilicus, which she informed me she had frequently had, continuing until the bowels moved or she vomited, usually

both occurring, then she would get well. When I saw her she was vomiting and had been frequently since midnight, but the bowels had not moved. There was great tenderness over the stomach and in the region of the umbilicus, slightly so over the appendix. Pressure increased the pain in the stomach and the vomiting most markedly. I was sure I had a case of appendicitis to deal with and watched the case very anxiously. During the day and following night the pain concentrated over the appendix and on the following morning the appendix was very tender with slight thickening. I was now positive that I had a case of appendicitis. All the time I was making every effort to move the bowels by salines and enemata which I could not push for the terrible vomiting. The symptoms were growing very discouraging; the temperature subnormal, pulse sixty; every indication of speedy dissolution. I advised an operation. As she was in a hotel, I had her removed to my hospital at two P.M., March 18th, operated and had her in bed by four P.M. of the same day. I operated thus early, knowing she could not long survive as she was.

On opening the cavity the first thing was the escape of a large quantity of serum. The bowels seemed perfectly healthy and not distended with gas. I found the appendix enlarged and inflamed. After removing and opening it, I found it engorged with pus. The whole organ was softened and the mucous membrane could easily be scraped off with the handle of the scalpel. After the effects of ether had passed off the patient was much better, and the sickness of the stomach which had been so severe ceased. On the evening of the 19th she appeared better in every way. Directly after the operation the temperature was 100½, pulse 99; March 19, temperature 99½, pulse 99; 20th, temperature 99½, pulse 80; 21st, temperature 98½, pulse 80, passed gas; 22d, A.M., temperature 99½, pulse 74, passed gas, was hungry, no pain, bowels moved slightly. Saw patient at noon; she was very restless, abdomen slightly distended and tender, and some retching, which had ceased after the operation. Saw her again after three P.M.; abdomen enormously distended, every indication

of patient sinking. I knew I had a case of intestinal obstruction, and opened the abdomen by median incision. Found the bowels enormously distended by gas, which I had first to get rid of by using a small trocar, before I could see or do anything for the patient.

And now comes the unusual and sad termination. This unfortunate woman had the remains of Meckels' diverticulum. Treves says: It starts from one to four feet from the ileo-cæcal valve in the ileum, and exists in two per cent. of adult cases. It usually occurs as a tube of the same structure as the small intestine, and its length varies, it sometimes extending as an open tube to the umbilicus, but more often it is a few inches long and may end in a free conical or globular extremity or in a fibrous end. It may cause obstruction in many ways. Its end may contract adhesions, beneath which the bowels may become strangulated; it may twist itself around the intestine, forming a knot; it may, on account of its adhesions, so draw upon the ileum as to kink it. In several cases it has been found in a hernia." Gray says: "It may become connected with the abdominal wall, or may be attached to some other part of the intestines." Gross says: "It may form the contents of abdominal hernia and may become impacted with foreign bodies."

In this case it was very large; at the point of attachment to the intestine nearly as large as the bowel. By tracing it up to its point of attachment, which was the umbilicus, I satisfied myself of its character. The bowels had become looped around this band, strangulating themselves. Above the constriction they were inflamed and distended; below they were quite normal. When the appendix was removed everything was healthy. I removed the constricting band, closed the wound and put the patient to bed very much exhausted. As she was a very delicate little woman to start with she could not withstand two capital operations so close together, so all my hopes of saving this young life were frustrated. She died the evening of the operation. This to me was a very sad experience. I am sure that this condition did not exist at the time of the first operation; if it had she would never have improved as she

did, and besides, no evidence existed at the time of the first operation, of such a condition of affairs. Strangulation by Meckels' diverticulum is not so unusual, but coming so close after operation for appendicitis is very rare.

The third case I report to illustrate the favorable results we get sometimes in seemingly desperate cases. Mr. C., of Baer Station, was first attended by Dr. Peters in October, 1895, for appendicitis, the attack and convalescence lasting seven weeks. On March 26, 1896, Mr. C. had a recurrence of his trouble. Dr. Peters being in attendance advised operation and kindly consulted me. Fully agreeing with Dr. Peters we had Mr. C. removed to my hospital. He had a large fluctuating mass in his side, distinctly outlined. My great anxiety when removing him was that the wall should not break, which fortunately it did not. After careful preparation I operated upon him, assisted by Drs. Briggs and Spruance. On opening the abdominal cavity fully a pint or more of very offensive pus escaped. By turning the patient on his side and flushing the cavity we finally got rid of the pus. On searching for the appendix the only part I could find was a few shreds, all the rest having sloughed away. Packing the cavity with sterilized gauze and providing for drainage, I put the patient to bed, and he made a complete recovery. Thinking some of you might possibly be interested, I show the appendix and pin I removed in the Delaware Hospital during the summer of 1894.

A Plan that miscarried.

The curtain had risen on the third act, and the momentary hush that preceded the resumption of the performance on the stage was broken by a stentorian voice from the rear of the auditorium: "Is Dr. Higginspiker in the house?" A tall, heavily-whiskered man, occupying a front seat, rose up. "If Dr. Higginspiker is in the house," resumed the stentorian voice, "he told me I was to come here and call him out at ten o'clock!" Whereupon Dr. Higginspiker, looking very red, picked up his hat and cane and walked down the aisle amid loud and enthusiastic applause.—*Medical News.*

ANNUAL ADDRESS.*

JAMES C. WILSON, M.D.,† PHILADELPHIA.

It is one of the agreeable duties of the President of the Philadelphia County Medical Society to submit, at the close of the year, in the form of an address, a brief review of the work and condition of the Society. This formality, which the custom of my predecessors, in this Chair has made a simple and concise statement of facts, is not without its usefulness. It brings to the attention of members matters of importance that otherwise many of them would overlook; it enables us to estimate the general value and importance of our work in the Society, our usefulness to the local profession, our weight with the State and National societies to which we send representative delegates, to compare the current events of the Society with its past, and finally to lay plans for greater usefulness in the future. I deem myself fortunate in being able to say to you that the Philadelphia County Medical Society has fully sustained, during the year that has just closed, its record of usefulness. The number of its scientific meetings was eighteen, one having been omitted in May, as coming into conflict with the session of the American Medical Association, and one stated meeting having been omitted in December, as falling upon Christmas. The four regular quarterly business meetings were held. The attendance at the meetings has been large. On more than one occasion this hall has been crowded to its full capacity. The average attendance at the scientific meetings has been fifty-three; the maximum, 121. During the course of the year forty-three new members were elected, of whom, at the close of the year, thirty-two had already qualified. The number of papers read during the year was fifty-five. A critical review of these communications shows that the majority of them are of the highest scientific and practical interest. No meeting has been without im-

portant and instructive papers and discussions of great suggestiveness and value. There has been the freest interchange of views among men whose training and experience justify explicit expression of opinion, but in no instance has there been the slightest violation of the courtesies of debate. A number of the papers have been devoted to the presentation of recent facts not generally known to the profession. Among these was the paper of Dr. Roussel upon "The Laborde Lingual-Traction Method in Cases of Threatened Asphyxia," that of Professor Parvin upon "Schleich's Method of Local Anæsthesia," and that of Dr. Fullerton upon "Posture in Difficult Labors." These papers and the discussions which they elicited proved interesting and instructive to the members of the Society.

The public spirit of the Society has been manifested in decided action upon questions relating to preventive medicine and the welfare of the profession. The Philadelphia County Medical Society has, during the past year, appointed committees and taken action on a law upon the subject of ophthalmia neonatorum, upon the matter of private hospitals for contagious diseases, upon the status of medical men in the navy; while a powerful committee has been appointed, consisting of one member from each ward in the city, to take action in the matter of irregular practitioners. The Society has made its power and influence felt in the meetings of the State and National societies by the character of its delegates and their intelligent action upon questions relating to the welfare of the profession and the extension of its usefulness. Particularly was this the case in the matter of Dr. S. S. Cohen's committee upon advertisements in the *Journal of the American Medical Association*.

Thus we have much upon which to congratulate ourselves. We are, however, far from being content. Restlessness and activity are necessary to prog-

*Read at the meeting of the Philadelphia County Medical Society, February 25, 1893.

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ress. This is not a conservative, but a radical society. It does not rest upon the laurels of its past, but strives for larger and broader influence in the activities of the future. To realize the best aims of the Society, its individual members must take personal interest in it. To attend its meetings, to bring to it in the form of papers and reports of cases the best and most recent observations, to take part in the discussions, are not enough. The members should speak of the Society to their friends, should make clear its purposes, should show that it is in the highest sense the local exchange of all that is best and most useful for the practitioner. We need a larger membership, a finer sense of professional brotherhood. Every regular practitioner within the limits of the county should be enrolled upon our list of members. So nearly should this be the case that to fail of election to the County Medical Society should be regarded as a disgrace, and I for one believe it would be well if every member of this Society wore, as do the members of military societies, upon the lappet of his coat, a button, as the insignium of membership in the most liberal and most useful of the medical societies of Philadelphia. In such an organization as this there are the means of elevating the tone of the profession, of increasing the knowledge of its individual members, of influencing public opinion in all matters relating to preventive medicine and sanitation.

I desire to call the attention of the Society to the fact that the date of the last edition of the Constitution and By-Laws is 1887. A new edition, embodying the changes to date, is needed. The matter is now in the hands of a committee and it is hoped that a report will be ere long forthcoming.

The thanks of the Society are due to the Directors of the past year for having brought to its attention the exact condition of its finances. Owing to methods of book-keeping which involve no criticism of former officers, it has come to pass that we find ourselves in debt. The Society has acted with honesty and decision in abandoning the publication of its *Transactions* for the current year in order to meet obligations incurred in the past.

My distinguished predecessor in this Chair, in his final address, raised a question concerning the advantage of changing the hour of meeting from 8.00 to 8.30. The reasons he adduced in advocating this change appeared to me at that time cogent. My experience during the year, however, has led me to believe that such a change should not be made without further careful consideration. Most of the meetings have been fully attended and a majority of the members have, as a rule, entered the hall within a few minutes of the hour named for the opening of the Society. Notwithstanding this, many of our meetings have been late in adjournment, often far past ten o'clock. In this connection I venture to suggest still further conciseness in the presentation of papers and in the discussions.

It is my painful duty to recall to the memory of the members the deaths during the year 1895 of their colleagues, Drs. S. K. Ashton, James Collins, Lewis D. Harlow, Albert G. Heyl, J. W. Hughes, George A. Rex, J. W. Brockbank, A. M. Hamilton, J. D. Schoales and G. J. Ziegler.

A New Danger to the Profession.

FRIEND.—I don't think the "X" ray should be used in medicine—

DOCTOR.—Why, it's being used now! We can get internal photographs of the patient.

FRIEND.—Yes, but some day the patient may be able to get internal photographs of the doctor's head and find out if he knows anything about the case.—*Puck*.

Medical Colleges in the United States.

In 1893 there were 132 medical schools in the United States. Of these two were preparatory, 94 regular, 16 "homoeopathic," 10 "eclectic," two "physio-medical" and eight graduate schools. The total enrollment of these colleges was 28,900 in the school year of 1892-3; 16,130 were in the regular and 1,445 in the homoeopathic schools. Of these 16,130 students the North Atlantic States claim 5,182; the North Central States 5,229; the South Central States 3,048; the South Atlantic States 2,192, and the Pacific States 479.—*Jour. Amer. Med. Association*.

PREGNANCIES FOLLOWING COMPLETE LACERATION OF THE PERINEUM.

JOHN M. CURRIER, M.D., NEWPORT, VT.

On June 1, 1891 I was called in haste, to attend Mrs. J. C., aged thirty-eight, in confinement, it being her eighth pregnancy. She was of French descent, tall, and strongly built, weighing fully 165 pounds.

On making an examination, I found that the os was quite well dilated, labor pains strong, with a prospect of a speedy delivery. I found the vaginal cavity very "roomy," and could not at first make out the unusual condition of things. Further search revealed that at some former labor there had been a rupture of the perineum and the recto-vaginal septum up fully three inches, but I could not learn at which one of her previous labors the rupture occurred. She had been delivered seven times previously, but I was the first physician who had been in attendance at confinement. All of her children were large and healthy. She had done the work for the family in all her pregnancies up to confinement and did not remain in bed above one week afterward.

She was delivered shortly after I arrived; the child weighed ten and one-fourth pounds. One of her former children weighed thirteen and one-half pounds; and none of them weighed less than nine and one-half pounds. Two days after confinement I ordered an injection to move her bowels, but her nurse said there was no "hole to put the syringe into." The woman has since that time given birth to two more large children, without any untoward results.

About the only inconvenience arising from the ruptured perineum is when she has a diarrhea, as she is then unable to retain the feces. A singular provision has arisen in her case that supplies the place of a sphincter; the posterior wall of the rectum bulges into the vaginal lumen, while the anterior recto-vaginal septum shuts down tightly over it and in a great measure prevents the escape

of the feces, unless they should be of a fluid consistence. She will take her child in her arms and walk off a mile or two without any inconvenience, and does not give up for "trifles." She continues to do the work for the family, and is in good flesh, looking healthy.

Where is the Fool-Killer?

The *Lancet-Clinic* tells of a young man who was left a large sum of money to buy all the medical books published in the English language for ten years. A professional buyer was to buy them and the young doctor attempted to read them. At the end of the first year he was back fifty books, with severe mental indigestion. At the close of the second year he gave it up in despair, and from that time on only read the titles and put the volumes away. Books accumulated in all parts, and an assistant attempted to arrange and classify them. At the end of the ten years the first five years' volumes were scarcely worth more than their cost in old paper. The most of the last five years' volumes were reproductions of the first year's, with some additions and changes. Finally he became involved and offered to dispose of these books, and the highest offer made for them was \$600. The actual cost had been \$16,000.

Can't be too Careful.

A doctor cannot be too careful. I once knew a young surgeon to operate for appendicitis on a large, roomy man, and had it not been for a timely autopsy he would not have known to this day that a good twenty-cent cigar dropped out of his pocket during the operation and was sewed up in the patient's annex. Had it not been for the *post-mortem* the cigar would have been a dead loss.—*Bill Nye in Medical Age.*

OPERATIONS ON OLD PEOPLE.

ALFRED GORDON, M.D.,[†] PHILADELPHIA.

For very many years the influence of age on an operation was considered of the utmost importance, and it was frequently the case that even minor operations were refused to those who had passed a certain limit, solely on account of the age of the patient, when other conditions were favorable. Recently, I was witness of a case in point in this city, where two surgeons refused to operate upon an aged woman for hemorrhoids which, however, were afterward successfully removed by a third physician. We were impressed to ask whether every aged person must forego relief from pain, and be unable to benefit by the recent advances in contemporary surgery, solely on account of their age.

We believe that in many cases it is impossible to rightly estimate the age of a person from the number of years they may have lived. The organic decadence which takes place in old age is so imperceptible in degree, and the loss of vital energy is so gradual, that it would often be embarrassing to define at what point old age begins. It is true that little by little the exterior appearance of a person is changed, but these signs are very variable in both sexes. The characteristic phenomena of old age take place rapidly in some people and more slowly in others, and this difference depends upon many conditions, such as difference of constitution, temper, environment, conduct, health, customs, race, climate, etc. Fleury, in his course of hygiene, said: "Of course there are old men of sixty, forty, and even twenty years, and there are men who are young and active in spite of the wrinkles on their faces and their gray hair." Hence, nothing can be less scientific than to estimate the degree of old age from the number of years the person has lived.

Researches in medical literature and observations in the hospitals, particularly those of Paris, during seven years,

confirm this statement. In one hospital the surgeons would refuse all cases of aged people, and in another a surgeon more courageous and not bound by routine has taken many of these cases, and in a large proportion of the operations has been very successful. A consideration of fifty-six cases reported in recent literature, of operations upon people who might be considered as old, leads of necessity to the conclusion that no surgeon has the right to refuse operative relief merely on account of the age of the patient. In these the cases terminating fatally are purposely reported in order not to destroy the value of the comparisons.

In twenty-one cases of operation for cancerous tumors we found two with a fatal termination, and one of the patients, aged sixty-five, was small and weak, and the other had albuminuria. These would have an unfavorable influence, even when the persons operated on were young. Strength is more necessary than youth. In fourteen operations for amputations and disarticulations, seven were fatal. One of these had gummy tumor in the lungs and a profound alteration of his kidneys and liver. The second died from phlebitis, the result of the digital compression on the groin during the operation. The third, fifth and sixth were habitual drunkards. The fourth had a diseased liver and kidneys, and the seventh was cachectic and had emphysema. From these facts it can readily be seen that the mere fact of old age had nothing to do with the ill success of the operations.

On examining the successful operations it was found that all were in good health except for the lesion necessitating the operation. In the comparatively few cases on record where healthy and strong old people died from operation it is likely that the cause of death can be as readily traced to some exterior cause, perhaps as much from a failure to maintain rigorous aseptic and antiseptic conditions as any other.

[†]Author of "La Vieillesse", Paris, 1895.

Under the modern conditions of asepsis and antisepsis there seems little reason for this fear of operation. The question arises whether this fear is because of the accidents due to anæsthesia or because of the danger of shock or of exhaustion from loss of blood. But if the person has a normal heart, if his arterial system is not atheromatous or if the atheroma is only on the earlier stages, there seems no valid reason to refuse operative relief. In fact, if there is no chronic disease of any vital or debilitating nature, operation should not be refused if there is any prospect of relief. The cases from which these conclusions are drawn are as follows:

Amputations and disarticulations:—MEDICAL AND SURGICAL REPORTER, October 21, 1893; MEDICAL AND SURGICAL REPORTER, January 1894; Memoires de Chir., t. II, 1880, Verneuil; Mem. de Chir., t. II, 1881; Mem. de Chir., t. I, 1881; Mem. de Chir., t. III, 1830; Hopital Saint-Antoine, 1893, Paris; Mem. de Chir., 1883; Mem. de Chir., t. III, 1883; Mem. de Chir., t. II, 1883; British Med. Jour., June, 1893; Gazette Med. de Paris, 1892; Mem. de Chir., t. I, 1873; Mem. de Chir., t. IV, 1896.

Operations for different kinds of tumors:—Mem. de Chir., t. II, 1880; Mem. de Chir.,

1883; Archiv. de Med., 1892; Mem. de Chir., t. III, 1883; Arch. de Med., 1892; Mem. de Chir., t. I, 1870; Mem. de Chir., t. I, 1870.

Operations for cancerous tumors:—Mem. de Chir., t. IV, 1836; Medical Press, August, 1864, Dublin; Faval. Thesis of Paris, 1877; Arch. de Med., 1892; Arch. de Med. 1892; Mem. de Chir., t. IV, 1893; Mem. de Chir., 1883; Mem. de Chir., t. IV, 1886; Mem. de Chir., t. IV, 1886; Arch. de Med., 1892; Mem. de Chir., 1888; Gaz. Med. de Paris, 1882; Mem. de Chir., t. IV, 1886; Arch. de Med., 1892; Arch. de Med., 1892; Mem. de Chir., 1888; Arch. de Med., 1892; Mem. de Chir., t. IV, 1886; Mem. de Chir., t. I, 1887; Mem. de Chir., t. II, 1880; Mem. de Chir. t. III.

Operations for hernia:—Arch. de Med., 1892; Arch. de Med., 1872; British Med. Jour., June, 1893; Mem. de Chir., t. IV, 1836; Hopital Saint-Antoine, 1894; British Med. Jour., November 3, 1894; British Med. Jour., November 3, 1894.

Cystostomy by supra-pubic operation:—Memorial des Lopitant de Midi., t. I.

Operation for a spermatocyst:—Mem. de Chir., t. IV, 1836.

Operation for hemorrhoids:—Mem. de Chir., t. IV, 1886.

Cholecystenterostomia:—Bulletins et Mem. de la Societe de Chir., t. XX, 1894.

Ovariectomy:—British Med. Jour., 1893.

Prolapsus uteri and recti:—MEDICAL AND SURGICAL REPORTER, August, 1893.

JACK-STONE IN THE OESOPHAGUS LOCATED BY THE RÖNTGEN RAY.

WILLIAM HENRY PRICE, M.D.,* PHILADELPHIA, PA.

Annie H., two and a-half years old, was brought to the dispensary on May 21, 1896, for treatment. Ten days before she put a jack-stone into her mouth and the mother seeing this ran quickly to take it out, but in her excitement pushed it down her throat by mistake. The baby began to choke and make swallowing efforts, but the stone did not appear. The mother then ran with the child to the drug-store and asked the druggist to see if he could get it out. He looked into the throat but could see nothing and advised her to go to a hospital. She applied to the dispensary of one of our largest city hospitals and they failed to locate the foreign body and

comforted the parent by saying that it would probably pass per rectum without difficulty.

The mother, evidently a careful observer, reported to me that she had examined every stool and no jack-stone had been passed. On the contrary the child was losing flesh and seemed fretful and not like herself.

I inquired as to the present symptoms and was told that aside from the general malaise and fretfulness, the patient could not swallow either solid or semi-solid food, but could swallow liquid foods, and further, whenever solid food was taken, it would be regurgitated in a second or two, and this always happened. The parents had fortunately always observed the vomited matter and in no

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case was the jack-stone present. From the history of the case it seemed probable that the foreign body was still somewhere in the alimentary canal. From the ability to swallow liquids and not solids, it seemed evident that its position must be in the œsophagus, for if the vomiting had been caused by an obstructed pylorus it would not have occurred so promptly after ingestion. Having made this provisional diagnosis,

I referred the case to the surgeons with the suggestion that if a Röntgen shadowgraph were possible, it would prove very interesting. The idea was adopted and a very successful skiograph of the chest was obtained which showed most beautifully the offending body to be in the œsophagus nearly opposite the second rib. The case then fell under the care of Dr. J. William White, who operated successfully and removed the stone.

COMMUNICATIONS.

A CASE OF INDIGENOUS PARASITIC CHYLURIA, WITH FILARIA NOCTURNA IN THE BLOOD.*

FREDERICK P. HENRY, M.D.,† PHILADELPHIA.

Fanny B., a married woman, twenty-nine years old, was born in Columbia, S. C., and spent the first twenty-seven years of her life in that town. Her twenty-eighth year was passed in Palatka, Fla., and her twenty-ninth in Philadelphia, where she arrived in March, 1895. Her father died from sunstroke, and her mother, for several years before her death, suffered from "shingles"—herpes circinatus. She had the usual diseases of childhood, except scarlatina. At the age of twelve she fell from a fig-tree, and soon afterward developed a large abscess in the left lumbar region, the site of which is plainly indicated by a cicatrix about three inches long, a little above and parallel with the posterior portion of the crest of the ilium. This abscess continued open for several months, but finally healed. A year after its closure another abscess appeared in the left iliac region, and also pursued a chronic course. Its site is indicated by a linear cicatrix, about two inches long, a little above and parallel with Poupart's ligament.

The patient suffered from what she vaguely described as an attack of malarial fever in March, 1895, but never

manifested any signs of malarial infection while in the South. She has had two miscarriages: one at four months and a half; the other at two months. Both were ascribed to persistent vomiting. Three weeks before her admission to the Woman's Hospital of Philadelphia, on February 16, 1896, she gave birth to a child at term. The labor was natural in all respects. Previous to the birth of her child she suffered from pain in the region of the kidneys. On the second day of her lying-in this pain became intense and continued for a week, when it abated somewhat. On admission, it was still complained of. On the third day of her lying-in she passed milky urine, and had difficulty in micturition on account of the occlusion of the urethra with what she regarded as stringy masses of mucus. These were, in reality, coagula of lymph and blood. The urine, after standing for several hours in a narrow cylindrical vessel, separates into two portions, of which the lower is distinctly hemorrhagic; while the upper has the appearance of milk or cream. Floating on the upper chylous layer are numerous coagula of a delicate, pinkish hue, and almost translucent, while at the bottom are a few small blood-clots. A little of the urine was shaken up in a test-tube with ether

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and set aside until the urine and ether had separated. The latter being then evaporated on a watch-glass, a distinct deposit of fat was obtained. The chylous urine contained a trace of albumin, but no sugar, and was free from casts.

I found this woman awaiting me at my clinic at the Woman's Hospital on Tuesday, February 18, 1896, and lectured upon her case as one of chyluria, probably parasitic. On the evening of February 19th I visited the hospital for the purpose of examining my patient's blood for the *filaria sanguinis*, taking with me a small microscope and making the search with a half-inch objective. I withdrew the blood from the finger about ten P.M., and examined several slides without finding the parasite. I left the slides at the hospital, and after my departure one of the resident physicians, Dr. Ida E. Blackburn, examined them with a stronger lens, and fortunately succeeded in detecting the *filaria*. Since then *filariae* have been found in almost every slide examined. They are not numerous, the maximum number observed on a single slide being five. The urine was repeatedly examined, the centrifugal machine being used to separate the parasites, but only on one occasion were they found in that fluid. With the specimen in which they were detected the centrifugal machine was not employed. The *filariae* have not been found in the milk of the mother or in the blood of the infant, and they are very few in number or absent from the blood of the mother during the day. The variety present in this case is, therefore, the *filaria nocturna*, the embryo of an adult which is alive in one of the lymphatic channels.

The patient was put to bed, and frequent examinations were made of her blood and urine. She was at first placed upon quinin and ergotin without any apparent effect, the urine continuing chylous and bloody, although in an intermittent manner. On February 25th, I examined the blood, and found *filariae*. I then directed leeches to be applied to the lumbar region, ostensibly to relieve pain, but in reality to test the question whether the leech might play the rôle of an intermediate host to the *filariae*. Three of the leeches were sent to me the next morning. I opened one of the

leeches at ten A.M., and examined its blood. *Filariae* were abundantly present, one slide containing six in active movement. The next morning (February 26th) they were still active. The same afternoon I found three dead *filariae* on one of the slides, and but one still living and languidly moving. At the same hour the *filariae* removed directly from the body were all living. On February 29th I opened another leech, and found a number of dead *filariae* in its blood—none living. It appears evident, therefore, that although the *filariae* may live many hours in the body of the leech, that animal does not play the part of an intermediary host to them.

On February 28, the patient was placed upon thymol (gr. ii every three hours), and coincidentally with its administration, the urine became normal in every respect, and so continued for seven days, when it again became chylous and bloody. The *filariae* during this interval were abundantly present in the blood.

On March 12, I ordered methylene-blue in two-grain capsules every three hours, being induced to do so by the remarkable statements of Dr. Austin Flint concerning the efficacy of this substance in a case of parasitic chyluria.¹

On March 13, I found Mrs. B. out of bed and dressed. Her appearance was good, her lips and cheeks being well-colored; the urine was deep blue; the eye-ground was examined by Dr. Gertrude A. Walker, ophthalmologist to the hospital, who confirmed my observation as to the absence of any morbid appearance in the retina. The patient was anxious to go home, but was persuaded to stay another week.

On Saturday evening, March 14, I obtained some blood from the finger as usual, and examined it the next morning. I had scarcely placed the first slide under the microscope when I detected two *filariae* (in the same field) moving with the greatest activity. I was unable to perceive that the *filariae* were stained in the slightest degree by the methylene-blue which the patient, at the time the blood was withdrawn, had been taking continuously for seventy-two hours. Her urine and feces were

¹ *New York Medical Journal*, June 15, 1895.

stained a deep blue, but the milk was uncolored. Thus far I have found no corroboration of Flint's statement that methylene-blue stains the filariæ in the circulating blood, much less that it exerts any deleterious influence upon them. My experience, although differing from that of Flint, in this matter, is precisely in accord with that of Laveran,¹ who found that the filaria perished a few seconds after it was brought into contact with a drop of a solution of quinin, of the strength of 1-1000, while methylene-blue (strength of solution not stated) does not hasten their death, and does not stain them until they are dead.

On March 17, Mrs. B. came downstairs to my clinic at the Woman's Hospital; a specimen of her urine, deeply stained with methylene-blue, was exhibited. Blood was withdrawn from her finger at one o'clock, and seven slides prepared. These were repeatedly examined by myself and an assistant, the result being that two filariæ were found in the seven slides. This was the third time the blood had been examined by day, namely, once before at one o'clock, when no filariæ were found, and once at eight A.M., when only one was discovered. It is evident that the parasites are much less numerous in the superficial capillaries by day than by night. This was the sixth day since the treatment with methylene-blue was instituted, and the results, thus far, were by no means encouraging. The drug appeared to be absolutely inert, so far as concerns the destruction of the filariæ. Different opinions as to whether or not the filariæ were stained, were expressed by those who saw the specimens. The majority thought they were not, but being on the lookout for such staining, I fancied that they had a faint bluish tinge.

On March 19, at one o'clock, the patient having been taking methylene-blue (two grains every three hours) for one week, I counted the blood-corpuscles. The number of red corpuscles per cubic millimeter was 4,100,000; the white were not increased in the number and were unstained. The hemoglobin-estimation was sixty-five per cent.

Five slides of rapidly dried blood were prepared, and no filariæ found. It is a

singular fact that on the previous day, while the patient was taking the methylene-blue as usual, the urine suddenly became quite clear and macroscopically normal.

I gave two slides of blood to Dr. Alfred Stengel, of the Pepper Laboratory of Clinical Medicine (University of Pennsylvania), in order to obtain his opinion as to whether or not the leukocytes were stained with the methylene-blue, which the patient had been taking continuously in full doses for more than one week at the time the blood was withdrawn. Dr. Stengel reported that he could find no evidence of blue discoloration of the corpuscles.

On March 20, at nine P.M., I again prepared a number of slides. The filariæ were abundantly present. I found them in eighteen out of twenty-one preparations, and, as I did not use a mechanical stage, it is possible that I may have overlooked them in the three slides in which the search was ineffectual. The serum of the blood was decidedly blue, and the filariæ of an exceedingly delicate bluish tinge. The methylene-blue had been taken by the patient continuously in full doses for nine days and had proved absolutely inert, so far as any influence upon the vitality of the embryos is concerned.

On March 21, the patient returned to her home. I omitted to state that shortly after the patient's admission I had her vaccinated, on the theory that an intercurrent infection might destroy the parasite. The vaccination was perfectly successful, but quite as useless from a therapeutic standpoint as the methylene-blue.

The foregoing case is of special interest both because it is the first of the kind observed in Philadelphia, and for the reason that it adds another to the list of those indigenous to the United States. It is impossible to say how long the filarial embryos have been circulating in the blood of this patient, but it is in the highest degree probable that the infection occurred either in South Carolina or Florida, and it is not impossible that the lumbar and inguinal abscesses, from which she suffered at the age of twelve, were due to the filariæ. Similar abscesses form part of the clinical history of filariasis. The exciting

¹Bulletins et Memoires de la Soc. Med. des Hopitaux de Paris, 3 serie, tome x, p. 738.

cause of the chyluria was probably the rupture of a dilated lymphatic during the expulsive pains of labor. The supposition that infection occurred at the age of twelve or earlier necessarily implies the circulation of the embryos in the blood for many years without giving rise to symptoms. In connection with this question of the innocuous presence of the filariæ in the blood of men the following case is of interest:

In the autumn of 1893, a well-known physician of Philadelphia consulted me about his son-in-law, who had resided for some years in Columbia, S. C., and latterly near Tampa, Fla. Filariæ were said to have been found in his blood by de Saussure of Charleston. Up to the time I speak of the symptoms had been those of intestinal indigestion, consisting chiefly of great abdominal distress, meteorism, irregular action of the bowels, great nervous excitement at times, especially toward evening. I examined the patient's blood in vain for the filariæ, and Professor Guitéras, who examined it twice, was equally unsuccessful. The time of my examination was about ten P.M., and I have since thought that my failure to detect the parasite may have been due to the fact that the patient walked to my office. The gentleman in question returned to his home in Florida, and a few months later passed chylous urine for the first time. The chyluria continued for one or two months, and has not returned. Of late the patient has been in a fair state of health, and free from the intestinal symptoms mentioned.

Post-mortem examination of those who have perished from parasitic chyluria has revealed enormous distention of the lymphatic vessels of the urinary tract, and sometimes also of the thoracic duct. A few months ago I exhibited before the Philadelphia County Medical Society a specimen of chyluria from a Cuban, whose blood I vainly searched for the filaria. I had but one opportunity of examining the blood of this man, and for that I was indebted to Dr. Charles W. Coburn, who was in attendance upon the case. Shortly after my examination the man died and an autopsy was held under very unpropitious circumstances. There was, however, no difficulty in ascertaining that the

lymphatic vessels, especially those of both renal regions, were enormously dilated and convoluted, many of them being of the caliber of an ordinary lead-pencil. The dilatation was most marked on the right side, and in the pelvis of the corresponding kidney there was a pale lymph-clot similar to the coagula passed with the urine during life. In this case it is greatly to be regretted that a careful dissection with a view to the detection of one or more of the adult filariæ was not possible. The time at our disposal was limited, and the light was derived from a single lamp which was held by turns by Dr. Coburn and myself, the autopsy being skillfully performed by Dr. Bundy, of the Woman's Medical College of Pennsylvania.

The importation of a case of filariasis into a city of the latitude of Philadelphia naturally raises the question whether the disease may become endemic therein, and there seems to be no good reason why it should not. The brilliant researches of Dr. Patrick Manson have established the fact that the mosquito plays the part of an intermediary host in conveying the *filaria nocturna* from man to man. At night the embryos swarm to the surface, while during the day they retire to the deeper vessels. Acting upon this knowledge, Manson exposed a filarial patient to the bites of mosquitoes, and found the embryos in the bodies of these insects, in which, in the course of from five to seven days, they attain a length of one-fifteenth of an inch. In the blood of man they measure from $\frac{1}{16}$ to $\frac{1}{8}$ of an inch, and are enclosed in a sheath, from which they make their escape in the viscid blood of the mosquito. The mosquitoes with the embryonic filariæ in their interior seek water in which to deposit their eggs. This function accomplished, they perish; the embryonic filariæ are liberated, and, through the medium of the water in which they exist, gain access to the human system. One or more of the ingested parasites attain maturity in the lymphatic system and continue for an indefinite period (in some cases for many years) to produce swarms of embryos. The latter being but $\frac{1}{1000}$ of an inch in diameter, readily traverse the lymphatic glands, and reach the blood-vessels via the thoracic

duct. It is through the plugging of the lymphatic vessels, especially those connected with the urinary tract, that the lymph and chyle become mingled with the urine. For further details concerning the life-history of this parasite, and the mode in which it occludes the lymph-channels, the reader is referred to the writings of Manson.*

In Philadelphia, mosquitoes are abundantly present during the summer and autumn, and have convenient access to the Schuylkill River, from which our water-supply is derived. The chance of a given individual becoming infected through the medium of a river of the volume of the Schuylkill is doubtless infinitesimal, but no one acquainted with the wonderful vitality of the embryonic *filaria* can deny its possibility. The surest safeguard against this and other sources of infection is filtration.

The *filaria nocturna* is now known to be indigenous in Europe, as appears from the report of a case recently studied by M. Font, of Spain.† The patient was a man, thirty-five years of age, who had resided all his life at Canet de Mar, with the exception of a short period passed at San Sebastian and Victoria. Canet de Mar is a town of 5000 inhabitants, on the shore of the Mediterranean, in latitude 41° 37' north, between Barcelona and the French frontier, and is a favorite retreat for veteran sailors, many of whom have visited the West India Islands. Dr. Ballester, in a communication to Font, reports having seen in the same town two cases of hematochyluria during fourteen years, in neither of which was there an examination of the blood. In Font's case the presence of the *filaria nocturna* was repeatedly demonstrated.

Thus far three species of *filaria* have been certainly detected: (1) *Filaria diurna*, (2) *Filaria nocturna*, (3) *Filaria perstans*. These names are indicative of the habits of the animal, the *filaria diurna* being found in the superficial vessels solely or chiefly during the day; the *filaria nocturna* solely or chiefly during the night; while the *filaria perstans*

is constantly present in the capillaries of the integument. The *filaria diurna* and the *filaria perstans* are confined, thus far, to the west coast of Africa and adjoining districts; while the *filaria nocturna* is pandemic in the tropics and endemic in certain sections of the United States. The adults of *filaria nocturna* have been frequently found; that of *filaria perstans* never, so far as I have been able to ascertain. In the opinion of Manson, the *filaria loa* of the eye of the negro of Old Calabar is probably the adult form of the *filaria diurna*. If it is not, he argues, then there must be another blood-worm yet to be discovered, for the embryos of the *loa* must escape from the body of their host through the medium of the circulation. The *filaria perstans* has been practically proved by Manson to be the cause of the fatal "sleeping sickness" of the Congo region.

While engaged in writing this article, my attention was called by Dr. Charles A. Oliver, of Philadelphia, to a remarkable case of *filaria loa*, recently reported by Dr. Argyll Robertson. The patient was a lady who had spent eight years in missionary work at Old Calabar on the west coast of Africa. Without entering into the details of this interesting case, I will merely state that in two successive operations Dr. Robertson extracted two *filariæ* (variety *loa*) from the ocular tissues, the first a male, the second a female. Both of these adult parasites are described by Manson in the course of Robinson's paper. The female was stuffed with embryos, but repeated examinations of the blood failed to detect any embryonic *filariæ* in that fluid. The latter fact certainly seems to refute Dr. Manson's hypothesis that the *filaria loa* is the adult form of the embryonic *filaria diurna*.

In a letter recently received from Dr. Manson, he says that America possesses the "unenviable distinction of possessing a *filaria* of the blood, which is possibly peculiar to itself. I found it in negroes from the island of St. Vincent, and I have little doubt but that it could be found in the negroes of the more tropical States of the Union. This *filaria* I have named *Filaria Demarquayi*, after Demarquay, the discoverer of *filaria nocturna*. It is a very small worm, not half the size of the *filaria* you are famil-

* Especially the articles in Davidson's "Hygiene and Diseases of Warm Climates"; *International Clinics*, April 1896; "Transactions of the International Congress of Hygiene and Demography," Seventh Congress, 1891.

† *Revista de Ciencias Medicas de Barcelona*, 25 February, 10 Marzo, 1894.

lar with. It observes no periodicity; it is sharp-tailed, and it possesses a sheath," etc.

This *Filaria Demarquayi** should, therefore, be added to the list already given, so that, at the present time, there are four distinct varieties of *filaria sanguinis hominis*.

The steps by which our present knowledge of the *filaria nocturna* has been obtained were gradual. The embryo was first discovered by Demarquay in 1863 in the liquid of a chylous hydrocele; next, in the blood by T. R. Lewis, of India, in 1872. In 1876, the adult parasite was found in a lymphatic abscess of the arm by Bancroft, of Brisbane, Australia, and is accordingly known to helminthologists as the *filaria Bancrofti*, this name having been assigned to it by Cobbold. Finally, our knowledge of the life-history of the parasite has been completed by the genius of Manson. We are irresistibly reminded of the analogous history of the discovery of trichiniasis, with which the names of Hilton, Paget, Owen, Leidy, and Zenker are associated.

In the United States filariasis can no longer be considered as an extremely rare disease, and it is probable that it is more prevalent in certain of our southern states than is suspected. Professor John Guit  ras, of the University of Pennsylvania, was the first to demonstrate the existence of endemic parasitic chyluria in this country,¹ and de Saussure², of Charleston, has published the clinical histories of twenty-two cases of filariasis observed in Charleston, S. C., from 1886 to 1890. Two cases of filariasis indigenous to Virginia have been reported by Dr. R. M. Slaughter,³ but in neither of them was the blood examined. In both there were hemato-chyluria and filari   in the urine, and in one filari   were found in the pus of an alveolar abscess. While I believe these cases of Dr. Slaughter to be genuine examples of filariasis, I cannot refrain from the criticism that the illustration accompanying his paper bears but a superficial resemblance to the embryonic *filaria nocturna*.

Another indigenous case is reported

by Dr. C. W. Mastin⁴ of Mobile, Ala., the patient being a young man, aged twenty-two, who had never been outside of Mobile and its immediate vicinity. In Mastin's case the filarious lesion was a chylous hydrocele. The filaria is also said to have been found by Weiss in the urine of a child that had never been out of Illinois.⁵ I am by no means sure that I have collected all the reported cases of indigenous filariasis; in fact, I have made no attempt to do so. Sufficient, however, has been said to show that the disease is widespread and not confined to tropical and sub-tropical regions.

In this connection I may remark that the embryonic *filaria nocturna* is capable of great resistance to cold. My slides, prepared in winter and kept in a cold room, showed the parasites active at the end of six or seven days; in fact, one lived for ten days. Exposure for many hours to a freezing temperature does not kill them, as proved by one of the methods employed by Manson to demonstrate "filarial ecdysis." This consists in placing the slide containing the filari   upon a block of ice over night, in order to cause a separation of hemoglobin from the red corpuscles. The effect of this degree of cold is to render the movements of the animal somewhat languid, but after withdrawal from the ice they become as active as before, and the embryos speedily escape from their sheaths.

Facts such as those stated seem to prove that nothing but time is needed for filariasis, the scourge of certain tropical countries, to become prevalent in our own, and demonstrate the vital importance of municipal filtration of our water-supply.

I have said little about treatment in the foregoing remarks because I do not believe there is any drug capable of destroying adult filari   in the human system. Surgeon-major E. Laurie of Hyderabad, reports two cases which he believed to have been promptly cured by thymol,⁶ the maximum dose being five grains twice daily. Walsh, of the general hospital of Calcutta, also reports success from the use of thymol. On the

* I would suggest that the last-mentioned parasite would be much more appropriately called *filaria Mansonii*.

¹ *Medical News*, April 10, 1886.

² *Medical News*, June 28, 1890.

³ *Medical News*, September 5, 1891.

⁴ *Annals of Surgery*, 1888, vol. 8, p. 320.

⁵ *American Text Book of the Diseases of Children*, Starr.

⁶ *Lancet*, February 14, 1891.

other hand, Crombie, of the same institution, has given two hundred grains of thymol daily in one case, and forty-five grains daily in another, without producing any effect upon the worms. As the latter justly remarks, "thymol is so exceedingly insoluble that it is improbable that any appreciable quantity of it left the intestinal canal."¹

I consider it a very fortunate circumstance that the case of Fanny B. came under my observation at a time when I was able to secure the co-operation of such an expert in photomicrography as Dr. Charles Lester Leonard, whose arduous work has been pursued in the Laboratory of Hygiene of the University of Pennsylvania. Dr. Leonard succeeded in obtaining *photographs of the living parasite*, and this is, I believe, the first time in which the living or filaria have been photographed under a one-twelfth oil-immersion lens, or, so far as I am aware, under any. The representations are, therefore, absolutely accurate, and necessarily take precedence of any drawings of the living or photographs of the dead nematode. To show the fallacy of drawings, I may say that one artist pictured the worm with a long cilium waving from its head, while another was unable to see anything of the sort in the same specimen. I may say, in this connection, that I am inclined to believe in the existence of such cilia, although they are not shown in the photographs; unless they are indicated by the blur in photographs taken. The point I wish to emphasize is that nothing can be represented in the photographs that was not present at the time they were taken.

I may say also that I have been unable to detect the "cephalic armature" described by Manson, although the "pouting" movement of the head was plainly visible. In mentioning my inability to detect the cephalic spine, or fang, I have no intention to impugn the accuracy of Manson's description. I attribute my failure entirely to my deficient training in this line of research.

In conclusion, I wish to express my thanks to Dr. Anna M. Fullerton, the distinguished physician-in-charge of the Woman's Hospital of Philadelphia, and

to her assistants, Drs. Blackburn and Carpenter, for their kind and skillful co-operation with me in my study of this interesting case.

Postscript.—I visited Fannie B. at her home on March 25, and found her in good condition. She informed me that since leaving the hospital, her baby's feces had been stained blue. She is taking ten grains of methylene-blue daily—two grains every three hours.

On March 28, the patient's milk was faintly stained blue. The treatment was continued.

On the evening of March 29 I visited the patient and prepared eleven slides, in every one of which I found filariæ in most active movement. She had now been taking methylene-blue since March 12. From the 12th until the 21st, the dose was two grains every three hours—sixteen grains per diem—and from the 21st until the 29th, it had been ten grains a day, in divided doses of two grains. The drug, in this case, has proved absolutely inert. The patient's urine was deeply stained, and her milk very slightly stained. The baby's fecal discharges were blue, and his urine also of a faint bluish tint. Filariæ of a very faint bluish tinge could be seen. The leukocytes were unstained. A few filaments of cotton on the different slides were stained of a faint bluish tint by the blood-plasma with which they were in contact.

From the foregoing it is manifest that my experience with methylene-blue in parasitic chyluria is entirely different from that of Austin Flint and Joseph N. Henry.²

The latter in his report to Flint says:

"The effects of methylene-blue in this case were decided and prompt. After the administration of two grains every two hours during the day on March 5, the parasites were very few at eleven P.M.; the only two found were deeply stained with blue, and their movements were extremely sluggish, the urine being clear but intensely blue. On the fourth and seventh days no parasites were found, although the treatment had been discontinued after the first day. On the eighth day the urine became milky, and on the night of the ninth day, filariæ were found in great

¹ *Lancet*, August 13, 1892.

² *New York Medical Journal*, June 15, 1895.

number, but their movements were not very active. On the tenth day the treatment was resumed, and continued for five days. Three days after, the blood being examined at night, a very few motionless filariæ were observed. Since that time and up to the present writing, the urine has been normal and the patient has been restored to perfect health."

Admitting the disappearance of the parasites in Joseph N. Henry's case, I believe it to have been a mere coincidence and in no way related to the administration of methylene-blue. I have given this drug in larger doses than were used in the case reported by Flint, and for a much longer period, without the slightest effect upon the parasite.

TYPHOID FEVER AS A COMPLICATION AND A SEQUEL OF INFLUENZA.*

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During the recent epidemics of influenza, the first of which occurred in the latter part of 1889, I observed cases of influenza that apparently developed into pure typhoid fever. Two instances of this sort I have reported elsewhere.¹ In my former paper a brief allusion was made to some statistics, which showed that out of 338 cases of influenza, six were complicated with typhoid fever. In one of these typhoid fever developed after an interval of normal temperature lasting twenty days. Three additional cases, two of which occurred in the practice of Dr. I. N. Snively, are reported herewith.

Reference is not had here to the rather numerous instances of influenza with marked intestinal symptoms that more or less strongly resemble typhoid fever. Da Costa has recently reported a case of the latter sort.² These can, as a rule, be easily separated from typical forms of typhoid fever. Thus, in Da Costa's case, the appearance of the tongue (dry, and red at the tip), the swollen belly, and the marked general debility, in the absence of localized inflammatory lesions, pointed to typhoid fever, but the presence of a markedly

irregular temperature-record, on the one hand, and the absence of either enlargement of the spleen or the typhoid eruption, on the other hand, showed the case to be one of influenza of adynamic type.

The chief object of the present paper is to confirm the statement made elsewhere that typhoid fever may appear as a late complication of influenza, or may follow this disease.

Among other affections which are known to be associated with influenza, as complications in varying degrees of frequency, are pneumonia, both croupous and catarrhal (with which latter disease pleurisy is always, and purulent pericarditis rarely, combined); gastro-enteritis, cerebro-spinal meningitis, etc. Again, its most common sequelæ are pulmonary tuberculosis, peripheral neuritis, perineuritis, melancholia, mania and neuralgia.

Cases of influenza which are complicated by typhoid fever are confessedly difficult of correct diagnosis without careful bacteriologic studies. I do not doubt that their dual nature has often escaped recognition. At all events, they have not been added to the literature of the subject previous to the appearance of my own article, so far as I know.

No bacteriologic observations were undertaken, either in connection with the cases reported previously or those herein narrated; hence, the evidence to show the clinical association of these two diseases has been gained only by

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¹ "A Statistical Study of Influenza, Philadelphia Hospital Reports, Vol. III.

² "Cases of Influenza Simulating Typhoid Fever and Cerebro-Spinal Meningitis," *University Medical Magazine*, Philadelphia, February, 1894.

observation of the symptoms at the bedside.

CASE I.—E. S., aged twenty-two, male, a student, was suddenly taken ill February 20, 1895. There were repeated slight chills, followed immediately by fever; intense headache; pains in the muscles generally, and great languor. On the following day I was called to his boarding-house, where he had betaken himself to bed. He presented great prostration and intense headache, the pain being situated especially deep in the orbits and in the region of the occiput. The temperature was 102° F.; the pulse, 100 per minute; and there was great pain in the muscles of the limbs, the loins, and the intercostal spaces. On the following day, as a result of the action of a purgative, he experienced severe gastro-intestinal pains with marked diarrhea. The latter symptoms were soon controlled by the use of paregoric and intestinal antiseptics. There was now some sore throat, tickling of the pharynx, and considerable dyspnea, but not much cough; nor were there any abnormal physical signs referable to the chest. His spleen was at this time not enlarged. The diagnosis of influenza was readily made. The course of the case for the next five or six days also fully corroborated this view. During the latter period the intense headache persisted. There was the usual restlessness, together with utter muscular prostration, and the burning and boring muscular pains, which changed their seat in the manner so frequently observed in influenza. The fever continued and was of irregular type, and the pulse was increased in frequency proportionately with the fever. At the end of the latter period, or about the time that deservescence was expected, the evening temperature continued at 103° F., and the morning temperature ranged from 101° to 102° F. The spleen now was slightly enlarged, the abdomen somewhat tender, especially in the ileo-cecal region; and there was slight diarrhea, amounting to two or three soft, ochre-colored stools daily. No new nervous symptoms had appeared, but the very severe headache showed little tendency to abate. The catarrhal symptoms, referable to the nose and throat, however, had completely subsided.

On March 3d, typhoid fever was sus-

pected. On March 4th (the twelfth day of the illness) the temperature was still pursuing the same continued type. The spleen was found, on palpation, to be considerably enlarged, and there appeared two characteristic typhoid spots on the upper part of the abdomen. The rose-spots faded away in the usual length of time, and subsequently a fresh and more abundant crop put in an appearance. The case was now treated as one of typhoid fever, to wit: by allowing a liquid, nourishing diet, by the use of cool baths, and internally quinin and salol in combination.

Apart from the fever, no other symptom demanded therapeutic measures save the headache and neuro-muscular pains, the latter affecting especially the loins and lower intercostal spaces. While the physical signs were negative, the patient was unable to take a deep inhalation at any time during the attack without experiencing pleurodynic stitches. These pains subsided with the decline of the temperature, and the subsidence of the typhoid symptoms—events which began at the end of the fourth week of the illness. Deservescence by lysis, so characteristic of typhoid, followed.

For the notes of the two instances following I am greatly indebted to Dr. I. Newton Snively, in whose practice the cases occurred:

CASE II.—“I was called February 28th, at four P. M., to see Mr. A. W., aged forty-two years, who reported that while at work (as a brass-finisher), one hour before my visit, he was suddenly seized with a chill of moderate severity, soon after which he began sneezing and coughing. He developed speedily severe headache, pains in the muscles of the limbs and trunk, and soreness all over the body. At the time of my visit his temperature was 103° F.; the pulse, 100; the respirations, 24. He had, thus early, a naso-pharyngeal and bronchial catarrh. The heart was acting strongly and regularly. The patient gave a history of having felt well up to within an hour of the chill. During the three succeeding days he was much depressed in spirits; he was restless and wakeful at night; and also complained of nausea and loss of appetite. The bowels were regular.

“Under the usual treatment for influ-

enza he rapidly improved. The temperature fell to normal on the fourth day, while the cough and myalgic pains were now, also, completely relieved. Appetite was restored, and the patient was apparently in a comfortable condition, so that I withdrew, with the instructions to the family and patient to send for me in case convalescence was in any way interrupted.

"Two days later I was sent for in the afternoon to see the patient again. I now found him with a temperature of 100° F.; the pulse, 90; the respirations, 22; and complaining of pain and tenderness in the abdomen, bleeding from the nose, and occipital headache. On physical examination I found the spleen slightly enlarged, the abdomen tympanic, the tongue heavily coated, the mouth dry, the pupils dilated, and the patient quite restless, but there was no delirium. The nurse reported six loose movements of the bowels during the previous twenty-four hours.

"From this time on the patient advanced rapidly into characteristic typhoid fever. The temperature-curve became very characteristic; the epistaxis grew worse and became so unmanageable that I plugged the anterior and posterior nares on March 9th. The typhoid eruption appeared extensively on the latter date; the diarrhea persisted; the heart became weaker in action and the sounds more feeble; the respirations hurried and there was a slight cough, with a few bronchial râles on auscultation. The expression of the patient grew very dull and heavy, and the cheeks were flushed. The tongue became very tremulous; it was very dry and brown, and sordes collected on the teeth. Headache became very severe, and there appeared moderate deafness, stupor, muttering delirium, picking at the bedclothing and imaginary objects.

"Dr. J. M. Anders saw the patient with me on March 9th and confirmed the diagnosis of typhoid fever. He also thought the case had primarily been one of influenza, followed by typhoid. I saw the patient on the morning of March 10th, when the nurse gave a rather favorable report, as the patient had slept more than on any previous night for a week; his pulse was dicrotic but regular, and marked 112; the temper-

ature was 102.5° F. The patient was taking milk and whisky regularly and in proper quantities. Nose-bleed was controlled by plugs; the mouth was kept moist by placing a large flat sponge (moistened frequently) over it. One hour after my visit I was again summoned, and, upon entering the room, found the patient dead. The nurse, who was an experienced graduate, reported that the patient had suddenly stiffened in bed, and when she took his pulse she found that it had gone up to 160, and was irregular and very weak; and that the patient seemed to be in a faint. She administered ammonium carbonate and gave a hypodermic of strychnin and digitalis, but with no effect, as the patient died a few minutes later. One hour after death large quantities of blood passed from the bowels, thus showing that the patient had died of an internal hemorrhage. He had shown evidence of the hemorrhagic diathesis from the first inception of the typhoid fever. No autopsy was made."

CASE III.—"Mr. J. L., aged twenty years, a Canadian by birth, sent for me February 23, 1895. He complained of severe pain in the retro-sternal region, and sharp myalgic pains about the chest. He had a severe cough, paroxysmal and painful in character; he also had acute coryza; he expectorated a scanty, tenacious mucus; his temperature was 102° F.; the pulse, 96; the respirations, 23. On physical examination, I found a few irregularly distributed subcrepitant râles. The respiratory murmur was feeble. The tongue was coated; the appetite poor; the bowels regular, and the abdomen normal. The man had severe headache, and was very restless at night, but not delirious. He was very weak and perspired profusely. He told me that he had been working regularly every day, and felt well until this attack came on. He was employed as a stone-carver, and, at the time he was taken sick, was working on the outside at the Bourse building. I saw him every day for four days, when his catarrhal symptoms, fever, and cough subsided. He now sat up out of bed and felt comparatively well, except that he was very weak and languid.

"On March 3, five days after I had

made my last visit, I was again summoned to the patient with the report that he was suffering with severe abdominal pains, diarrhea, and vomiting.

"I found him with a heavily coated tongue; complete anorexia; a distended and tender abdomen; the temperature, 101° F.; the pulse, 90; the respirations, 20. I ordered a mixture of salol and bismuth, and put him on a liquid diet. From this time on he passed through a characteristic attack of typhoid fever; the temperature was higher each day than on the preceding, at first, and always higher in the evening than in the morning. The small, slightly elevated, rose-colored spots appeared on the abdomen on the 10th of March, and the spleen was manifestly enlarged. He had the characteristic nervous symptoms—headache, stupor, twitching of tendons, etc. The urine was small in

quantity and very slightly albuminous. Convalescence set in after an illness of twenty-eight days, and was marked by falling out of the hair, anemia, etc."

In my present and previous articles are contained the notes of five cases in which typhoid fever was either a complication or a sequel of influenza. It cannot, in view of the statistics before quoted, be claimed with justice that typhoid fever is a frequent complication or sequel of influenza. That the epidemic prevalence of influenza is attended with an increased number of cases of typhoid fever, however, is also shown by tracings. I am of the opinion that further observation of influenza, with special reference to its association with typhoid fever, will confirm the dictum that the occurrence of the former disease renders the body more than ordinarily receptive to the typhoid bacillus.

CURRENT LITERATURE CONDENSED.

Subphrenic Abscess and Its Relation to Pyothorax.

Of five cases of subphrenic abscess which Dr. Beck had observed, only twice was he able to make a correct diagnosis before operation. The fact that subphrenic abscess is very often confounded with pyothorax is well known, and such errors impress one gravely with the necessity of widening the limited diagnostic knowledge on the subject. Subphrenic abscess may even be said to take the rank at the present time of appendicitis of yore, when, occasionally, an autopsy demonstrated that under extremely rare circumstances perforation of the vermiform appendix, caused by "the obligate grape-seed," may occur, "a cure in such unfortunate cases of course being out of the question." As soon as the profession-at-large will take the same interest in subphrenic abscess that they do in appendicitis, the number of cases, which in the whole present literature amounts to less than 200, will rapidly swell to an enormous number, and accordingly will the

prognosis, except in those of malignant origin, be most favorable.

After referring at some length to the fact that the history of the case was a most important guide in differentiation, and mentioning at some length the various physical signs to be detected, Dr. Beck said: It was sometimes impossible to distinguish an encysted pyothorax from a subphrenic abscess. The pathognomonic signs of such effusions urged by Leyden were absence of cough and expectoration, slight displacement of the heart, and rapid change of note if the patient is rapidly turned. But pleuritic effusion, particularly pyothorax, sometimes occurs without these symptoms. The motions of the exploratory needle, introduced into the abscess, were also regarded as pathognomonic. But, bearing in mind that in subphrenic abscess the function of the diaphragm is greatly impaired, and that, furthermore, the point of the exploratory needle may be fixed by the diaphragm as well as by the abscess membrane, neither the presence nor the absence of the motions can be regarded as determining pathognomonic factors.

¹Dr. Carl Beck, New York City, Section of Surgery and Anatomy, American Medical Association, Atlanta, Ga., May 5, 1896.

The author referred to Litten's diaphragma-phenomenon and to Jendrasik's ability to note a well-marked concave undulating curve, parallel to the costal margins in the mammary as well as the axillary line during deep inspiration, but does not consider the value of the former of the two methods established. Aside from the history he thinks three are but few absolutely reliable pathognomonic data for the diagnosis of subphrenic abscess, and the main question will practically always remain as to the presence of an abscess.

Dr. Beck says that if the first trial be negative, the needle should be introduced several times into different portions as the pus cavity may either be of small extent, may contain a cheesy accumulation, or may be divided into several minor cavities by adhesions. In the first event the cavity may be missed altogether by the exploratory needle, and in the second the needle, being introduced into the solid cheesy mass, can draw no pus. After each negative result, a wire should be pushed through the needle (which must not be of too small a calibre). Thus, some pus, which had remained adherent to the inner surface of the needle, will become attached to the wire. Occasionally, it will be useful to fill the syringe with sterile water after the operation and force the water through the needle into a Petri dish. In case cheesy masses are present, small particles are sometimes drawn into the calibre of the needle, which cannot be seen by the naked eye, but which, by being mixed with the sterile water, can be recognized under the microscope. In case the microscope does not give sufficient information, resort should be had to cultures of the fluid. The treatment of pyothorax is practically the same as that of subphrenic abscess, that is, resection of a piece of a rib, as it is only in this way that a sufficiently wide opening is secured for thorough evacuation.

Cholelithiasis and Cholelithotomy.²

Dr. Dunn's paper was based upon a study of forty cases of gall-stone disease and a review of the chief literature of

the subject. As a result of this experience he has been impressed with the highly overdrawn notion of biliary colic and the misinterpreted view of the symptomatology of cholelithiasis prevalent in the general professional mind; the mistaken prominence given to jaundice as a symptom, and the tenacity with which a childlike pathology explaining its presence or absence on the purely mechanical action of the stone is held. Jaundice is a comparative infrequent symptom, at least in the earlier course of the average cholelithiasis, and cases not rarely run their whole course without icterus. The author reported a case of a young and otherwise healthy woman, who died as a result of six weeks' attack of biliary colic with nearly constant pain, tenderness and vomiting. She had had but one previous attack of short duration nearly a year before. A trace of bile was present in the urine, but at no time had there been a trace of icterus observable by the friends, trained nurses or physicians.

At the autopsy three gall-stones were found in the gall-bladder and two in the common duct. The presence or absence of icterus must not have too strong an influence on one in locating the stone. If the attacks be frequent, the calculi not passed and the symptoms not relieved by a reasonable hygienic and medical course of a few weeks' duration, so safe an operation as cholecystotomy at this stage is doubly preferable to further delay, even though no very threatening symptoms have developed, first, as the cheapest escape from present suffering and, second, as a preventive measure against the ever-possible dangers of cholangitis, duct impactions, etc., which may entail a much more dangerous and trying operation upon a patient. In time the proper treatment of cholelithiasis, with few exceptions, will be considered to be early surgical interference, although, so long as the patient is in no apparent danger, a rational non-surgical management through one or several attacks as good judgment may dictate, cannot be condemned, and is to be heartily advised unless circumstances offer very perfect surgical advantages.

When, however, after several days' duration only a partial peace is declared, the general health begins to fail, local

² Dr. Charles H. Dunn, Minneapolis, Minn., Section of Surgery and Anatomy, American Medical Association, Atlanta Ga., May 7, 1896.

tenderness, lesser paroxysms recur, jaundice and infection threaten, one is confronted with far more serious situation and the indications for interference may be termed imperative. The practical distinction between relative and imperative indications in surgery is of the greatest importance, and too often overlooked, and it seems a very pertinent question whether or not operation should be advised in the midst of a recent attack of colic, etc. Kher, having, as he believes, learned to distinguish between gall-bladder colic and gall-duct colic, advised waiting when the latter exists, lest the stone be left in the choledochus or a difficult choledochotomy need to be performed. Many will be quite unable to make this differentiation with any certainty, while to delay long with a calculus in this most dangerous locality will often jeopardize the patient. The diagnosis once positively made, it would appear less difficult for a surgeon to approximate reasonably the burdens and the dangers of the disease in a given case, and to distinguish between when to advise waiting, when to recommend operation, and when to insist upon it, than to formulate rules for others. One prominent authority seems to regard the size of the stone as having an important bearing upon operative indications, but, in the first place, one can foretell absolutely nothing as to the size of the stones before they are removed or passed, and in the second place, however much the theory that a small stone ought, and a large stone cannot be passed, may appeal to rational simplicity, the case above mentioned of the young woman proves that the facts fail to follow mathematical fancy. All modern observations go to show that nine times out of ten the gall-stones occupy the gall-bladder alone, and ninety-five times out of a hundred they occupy the gall-bladder alone or it and the cystic duct alone. In the vast majority of cases, therefore, the indication appears to be to open the gall-bladder, remove the stones and debris and temporarily drain the diseased organ. Dr. Dunn thinks cholecystotomy with temporary fistulae is the operation of election in the average cholelithiasis, and the one to be chosen probably eight or nine times out of ten. Various conditions in

connection with the remaining minority will demand a modification in the operation. In certain cases choledochotomy is the choice operation, but it is always difficult, frequently dangerous, and sometimes impossible of practical execution.

Health resorts are in danger from the consumptives who go to them, according to the *Journal of Hygiene*. In a recent number it says: "Forty years ago, Mentone was a happy village in France, where lived peasantry happy in their farms and in their superb physical state, conditioned by the climate. It was discovered that the region was a most healing one for consumptives, and it became the Mecca for the unfortunates of Europe so stricken. The inhabitants abandoned their farms to wait upon the strangers. The strong healthy women forsook their dairies and became the washerwomen of the consumptives' clothes. No precautions were taken; the disease was not then understood as now, the theory of tubercle bacillus not having been discovered. The place to-day is bacillus-ridden, a pest hole, death itself. The hitherto strong inhabitants are emaciated, a coughing, bleeding people, filled with the germs of consumption. The soil and air are both contaminated with the tubercle bacilli. It is no longer a health resort." The same fate, it is believed, awaits many other similar localities unless active measures are taken to destroy all germs. This will be a most difficult task, because consumptives themselves, as a rule, are not thoughtful of the danger they spread, or of the rights of others. They should bear in mind that if all others had been careful, they, too, might have escaped.

United States Navy Surgeons.

The minimum number of physicians allowed is 175. There are, however, at the present time, of all ranks, but 161, and very few, if any applications. One would suppose the United States navy would be more attractive to medical men than the army service, but such is not true, owing to the fact that staff officers are excluded from many of the privileges of their rank—privileges which accrue to all officers of the line.—*Medical Age*.

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PHILADELPHIA, SATURDAY, JUNE 20, 1896.

EDITORIAL.

THE LESSON OF IGNORANCE.

We have just come from an autopsy to which we were invited because the symptoms had pointed to disease of organs in which we are especially interested. Two skilled and experienced physicians had attended the patient, and had made diagnoses which were only partly right. Five physicians, after careful inspection of the viscera and after reviewing the case in the light of the clinical symptoms, physical and urinary examinations, acknowledged themselves unable to find an adequate cause of death. True, evidences of disease were found and certain examinations had been omitted which might have implicated the blood or the central

nervous organs. Yet, these seemed important only because death could not reasonably be assigned to other causes.

At this season, when the ten months' session of medical societies is drawing to a close and the record of our own and of others' achievements is fresh in our memories, and while the tributes paid to our profession by commencement orators are yet ringing in our ears, it is well to take counsel of some such occurrence as that just cited, and to gain humility in pondering on the limitations of our knowledge.

"Why pay a physician two dollars for guessing at your case?" was the appeal of a celebrated advertiser of pat-

ent medicine. In a sense, the slur is deserved, for we recognize and publish our fallibility by refusing to guarantee cure. Unfortunately, the laity do not always realize that if careful training and experience cannot raise the regular physician to the plane of certitude, a ready-made mixture prepared by a man with no special knowledge of medicine and applied without due consideration of symptoms and diagnosis, must act by chance without even the benefit of clever guess-work.

The fact that we of the present comprehend the true inwardness of disease as our predecessors could not, that we have at hand methods of precision in diagnosis, where they were compelled to rely solely on inductive reasoning and tell-tale symptoms, that we have superseded some of their most trusted drugs with better ones, may puff up with pride the thoughtless man and cause him to smile at the puerile efforts of past generations of physicians, but the thoughtful man sees, in these very changes, the prophecy of his own humiliation. Young men in the profession can recall the fate of a president of the United States who had the best medical and surgical care of a decade and a half ago, but who died for lack of application of operative and antiseptic principles that are now classical.

Contrast the complicated and artificial teaching about "typhlitis, perityphlitis and paratyphlitis", which prevailed scarcely more than five years ago, with the straightforward consideration of inflammation and sepsis in and about the appendix, as revealed by surgical pathology. Note the precautions against hernia in sewing the abdominal wall in layers, instead of one set of wire sutures, the precision with which abdominal operations are now undertaken as compared with the vague search for the hidden cause of pelvic trouble which act-

uated the gynæcologist of less than ten years ago; the practical results of surgery of the pericardium, brain and cord which were scarcely more than prophesied in 1886. Reflect upon the details in which antiseptic methods have been simplified and rendered more certain, even since 1890. Contrast the diagnostic advance in the matter of diphtheria alone, with the elaborate and utterly impracticable differential diagnosis between diphtheritic and croupous membranes which was taught within the last three years. Consider the limitations which we have learned to put upon the use of antipyretic drugs. Recall the mysterious and absolutely unsupported efficacy which was ascribed to electricity by gynæcologists a very few years ago. These and a dozen other subjects might be cited to show how radically wrong were the advanced medical men of five or ten years ago when compared with those of the present.

The next decade will probably witness the isolation of the germs of scarlet fever, measles, syphilis and other common and unquestionably infectious diseases, whereas our diagnostic use of bacteriology is now practically limited to tuberculosis and diphtheria, with possibilities in the way of typhoid, cholera and a few other diseases. In all likelihood, the usefulness of animal extracts and of immunizing serums will be placed either beyond or out of the question; the merits of immersion in typhoid and other fevers, and many other mooted points, will be decided as definitely as the issue of antisepsis and the Bergeron treatment of consumption. Unknown instruments and new drugs will be in daily use and, "looking backward," we of ten years hence will condemn ourselves of to-day as bunglers and will consider as malpractice some of our most conscientious efforts.

Next in importance to knowledge, is

the realization of ignorance. A problem clearly stated is half solved. It is well for us to pause occasionally in the midst of a busy practice and admit, to ourselves at least, that we are crude and superficial in our methods. When we say dyspepsia, we are only on the road to a diagnosis; constipation, diarrhoea, paralysis, anæmia, are merely the technical expressions of obvious conditions, not of accurate medical conceptions. Nor, on the other hand, must we imagine that mere measurement is the acme of science, for quantitative results often fail to throw light on the processes of disease, and some men blind themselves

to the real issues by confining their attention to mathematical and chemical problems.

Careful thought, modest effort, persistent striving to reach a goal that constantly recedes from us, are the duty of the physician who would feel, not that he has attained the perfection of his art, but that he is keeping well to the front. Too often, one meets professional brethren whose ignorance breeds a comfortable sense of self-satisfaction. When this happens, the only safe-guard against conceit and laziness is the contemplation of the unsolved problems that lie before us.

ABSTRACTS.

THE MANAGEMENT OF PELVIC PRESENTATIONS.*

R. G. McKERRON, M.A., M.B.

A knowledge of the management of pelvic presentations is important from the active assistance these presentations usually demand, and important also from the difficulties which in practice they occasionally present. My excuse for bringing so everyday a subject before you, however, lies in neither of these considerations, but rather in the unsatisfactory and discordant directions for their management to be found in text-books and in obstetric literature.

It is not my intention to occupy the time of the Society with those details of management on which writers and authorities are agreed. It is the points of difference that I desire to bring under your notice, and to reduce, if I may use the expression, to a common working denominator. These differences are mainly to be found, not in the methods of meeting exceptional difficulties, but in the routine management of normal easy breech cases.

In the conduct of the first stage in pelvic presentations there is no disagreement. The membranes must be more carefully kept intact than in vertex cases, and the reason assigned is that the breech does not so well adapt itself to the lower uterine segment, and in consequence does not so readily dilate the os uteri. It is, however, in the amount rather than in the rate of dilatation that the breech is inferior.

When the membranes do rupture it is the custom with many practitioners at once to take down a leg. For this they have the authority of Smellie and others. I shall not discuss that treatment further than by saying that it may avert future trouble, and is at that time usually very easy. As a prophylactic measure, however, it is opposed to recognized usage.

Till the birth of the breech there is no essential disagreement among teachers. It is then that the risks to the child increase to a dangerous degree, and the

* *Practitioner*, June, 1896.

differences amongst authorities as to treatment are really the expression of the various opinions as to how those risks may be reduced to a minimum. These opinions resolve themselves mainly into two lines of action—into two methods of treatment: (1) The routine employment of traction on the partially-born trunk; (2) the employment of traction only when nature, unaided or partially aided, has failed.

If I were to inquire into the usual practice of the members here I am convinced I should find it to be the almost invariable custom to terminate delivery artificially after the expulsion of the breech. That is the teaching of Professor Stephenson in our University, whose rule is, "Take the delivery into your own hand immediately on the birth of the breech; do not wait for pains." It is my own custom in almost all circumstances, and I mean to justify it. Nevertheless, such treatment is opposed to the teaching of our leading text-books; nor can I find it advocated anywhere in obstetric publications. All maintain that routine traction is undue and unwarrantable interference, and is the main cause of the difficulties that beset an ordinary breech presentation—viz.: (1) Extension of the arms which causes undue delay; (2) extension of the head, which presents a large diameter, thus endangering the life of the child and the perineum of the mother.

Now it must at once be conceded that the effect of traction pure and simple is to produce extension. How this occurs is clear. If left entirely to nature the uterus, at the same time that it propels the body, keeps, by its firm contraction, the arms in their natural position on the child's thorax. Traction, on the other hand, acting through the body, leaves the arms free, and with the result that, retarded by friction, they fail to keep pace with the body and thus become extended alongside the head. I would point out, however, that where traction is not made until the umbilicus is born, the arms have already entered the pelvic brim, and the resulting extension may not be complete. Traction also, no doubt, tends to extend the after-coming head, though I am convinced that in this respect its effect is much exaggerated.

With the premises, therefore, of those who oppose traction we agree, but not with their deductions as to treatment, and the grounds of our dissent are embodied in the four following propositions:—

(1) That even where left to nature, extension occurs in a considerable proportion of cases.

(2) Where extension is artificially produced it can in normal cases be easily remedied.

(3) Traction forms the most speedy, and therefore, in the interests of the child, the safest means of completing delivery.

(4) By appropriate treatment, combined with traction, I claim that extension can almost invariably be prevented in cases where, if left to nature, it would not have occurred.

If these propositions can be established they supply a rational basis for the treatment which inquiry has led me to believe is that generally adopted among practitioners. Of the first, which is universally admitted, it is unnecessary to adduce proof. To the second, also, I may claim that there will be little opposition. In the majority of cases extension of the arms, artificially produced, and extension of the head are conditions that are easily treated. Where difficulties do occur there will usually be found to exist some disproportion between the child and the passages—a condition in which spontaneous extension would most probably have taken place.

Now as to our third contention, that traction forms the speediest and safest means of completing delivery. Against this proposition there is a great weight of authority. To traction are attributed the difficulties that beset an ordinary breech case. "It is, no doubt, tempting to use traction on the partially-born trunk in the hope of expediting delivery; but when it is remembered that this is almost certain to produce extension of the arms above the head, and subsequently extension of the occiput on the spine, both of which seriously increase the difficulty of delivery, the necessity of leaving the case as much as possible to nature will be apparent" (Playfair).

Now if left to nature, as our text-

books recommend, we know a pain may not follow the expulsion of the breech for several minutes, more particularly if an anæsthetic has been given. What are the risks that the child meantime is running? These begin when the breech is just emerging from the vulva in pressure on the cord at the brim or at the cervix. They greatly increase with the birth of the umbilicus, reaching their maximum when the head begins to engage the upper pelvic strait. With the increasing danger there is a decreasing expulsive power. How, then, is it proposed to meet these risks? Galabin lays down that "unless there are signs that the child is in imminent peril, there must be no further interference, save telling the woman to bear down and abdominal pressure." Then if the child is in peril it is necessary to have recourse to extraction. Reynolds again, in an American text-book of obstetrics, says, "He who interferes in a breech delivery should feel that he is likely to be confronted by the necessity of a manual delivery of each and every portion of the child's anatomy as these portions successively approach the pelvis." The teaching of Playfair, Lusk, Schroeder, etc., is in effect the same. They propose to risk the dangers of artificial extension with a child *in extremis*. Were we to follow such practice and wait till the child is in imminent peril, then if any difficulty is experienced in getting down the arms or in delivering the head the child is almost certainly lost. By traction, therefore, employed in a routine manner after the birth of the breech we gain time; and though we may introduce a difficulty, the difficulty is one that can easily be removed and which there is time to remove. Failure to get down the arms with the necessary rapidity is, I admit, a frequent cause of death; but it will be found in those cases that the pelvis is narrow, or the child disproportionately large—the very cases in which nature fails and the artificial extraction of the arms becomes necessary.

Though extension of the arms is thus a difficulty that in normal cases can be readily dealt with, yet it is a condition that necessitates the introduction of the hand into the vagina. This means pain to the patient. It means also increased

risk to the maternal tissues. If possible, therefore, it should, in the interests of the mother, be avoided. Now I hold that it is possible, even where traction is employed, to prevent extension in the majority of cases. It is some time since first I suggested the possibility, and I have frequently demonstrated it in practice. The uterine contraction is, it will be remembered, nature's method. This we can imitate by firm pressure applied over the now diminished uterine tumor. If, then, traction on the partially-born trunk be combined with strong, properly-applied abdominal pressure, it will be found that the arms in a great many cases will emerge either in their natural flexed position, or extended only partially—to a degree that can be remedied by the introduction of one finger into the vagina.

Brief notes are given of several cases where this procedure was adopted with success. One of these, it will be observed, is particularly instructive. For over an hour the right shoulder, with arm prolapsed, rested on the perineum. I was fortunate in having a very efficient assistant. After turning under full anæsthesia, I gave instructions how and where to apply suprapubic pressure during traction. To my surprise the left arm emerged flexed on the thorax, while the other was found only slightly extended. The head presented no difficulty.

CASE 1.—E. M.—. 1-para, aged eighteen. Duration of second stage, two hours. Leg taken down; clinical clerk carefully instructed as to abdominal pressure. Both arms emerged flexed on chest; exit of head at outlet delayed for about three minutes (due not to extension so much as to difficulty of carrying body forward owing to height of bed). Child alive; weight, six and a half pounds.

CASE 2.—Mrs. McK.—. 14-para, aged forty-two—previous labors difficult; short, stout in build. After very long first stage membranes ruptured and a leg brought down; no nurse; suprapubic pressure entrusted to a neighbor. Both arms extended, got down with some difficulty owing to disproportion between child and pelvis; head came with surprising ease. Child living, female; weight, eleven pounds. (Ab-

dominal pressure unsatisfactory; no anæsthetic.)

CASE 3.—Mrs. McG.—1-para, aged thirty-nine—long first stage. After one and a half hour, as breech did not enter brim, leg brought down under anæsthesia; strong suprapubic pressure combined with traction; one arm emerged in normal position, the other under chin, and easily removed by insertion of one finger into vagina; no difficulty with head. Child alive, male; weight, seven and a half pounds.

CASE 4.—Mrs. A.—5-para, aged twenty-nine; midwife in attendance. When seen, right shoulder on floor of pelvis for two hours, arm protruding; turned under full anæsthesia; labor rapidly terminated by traction combined with suprapubic pressure; left arm in natural position, right arm only partially extended; no difficulty with head. Child dead, well developed.

CASE 5.—Mrs. F.—1-para, aged twenty-two. Two hours after rupture of membranes leg taken down under anæsthesia with difficulty, owing to narrow brim; by combined method both arms extended, and with much difficulty released after about ten minutes; no difficulty with head. Child dead; weight, seven and a half pounds. (Subsequent measurement showed narrow brim; sp. 12, nine and a half inches; cr. 12, just under ten inches.)

CASE 6.—Mrs. B.—9-para, aged thirty-nine—previous labors difficult. In first, craniotomy; in seventh, version after failure with forceps; in eighth, version. Finding occiput posterior, in light of past history, I resolved to turn. With os three parts dilated, membranes having ruptured several hours before, I performed internal version, with traction and abdominal pressure made by my clinical assistant, Mr. Alexander; arms only partially extended, both humeri remaining under chin; no difficulty with head. Child alive; weight, nine and three-quarter pounds.

CASE 7.—Mrs. M.—6-para, aged thirty-two—previous labors fairly easy. Os fully dilated; breech arrested at brim; dorso-anterior L; under anæsthesia took down leg; traction combined with suprapubic pressure; delivery rapidly completed; arms retained in normal position; both elbows emerging from

vulva. Child dead several days; weight, seven pounds and three ounces.

I do not claim that this combined method is invariably successful in preventing extension. It has, as will be seen, occasionally failed, but I think I may say only where the child was unusually large, as in Case 2, where the woman was short and stout, with previously difficult labors, or, as in Case 5, where the pelvis was disproportionately small. In both there is reason to believe spontaneous extension would have occurred. In not one of the cases was difficulty experienced with the head, and in none was the perinæum ruptured.

Now a word as to the most effective method of applying abdominal pressure. It should be entrusted, where possible, to a skilled assistant. Both hands should be well and uniformly spread over the fundus and sides of the uterus. The main pressure should, if possible, be directed towards the thorax of the child, the position of which must always be defined. Throughout the traction the pressure must be strong and continuous. The best results will be got by this method when the abdominal wall is lax. To this end anæsthesia is an advantage.

Suprapubic pressure is not, I am convinced, sufficiently emphasized as a routine measure in the management of breech cases. In some text-books its aid is invoked only when nature has failed, and not as a routine auxiliary. I have dwelt mainly on its effects in retaining the arms *in situ*, but it has an even more important use in aiding, after delivery of the shoulders, the birth of the head, on which the uterus now acts at a great disadvantage. Here, too, it tends to prevent the extension attributed to traction.

Not According to Professional Ethics.

PILLS.—Dosem has been expelled from the medical association for advertising contrary to the code.

SQUILLS.—How did he advertise?

PILLS.—He was called to lead the prayer meeting the other evening, and he walked up front and gave out the hymn, "The Great Physician now is Here."

SOCIETY REPORTS.

THE PHILADELPHIA COUNTY MEDICAL SOCIETY.

[OFFICIAL PROCEEDINGS.]

Stated meeting held February 26, 1896.
The President, DR. JAMES C. WILSON in the chair.

The PRESIDENT delivered his
ANNUAL ADDRESS.

[See page 770.]

DR. FREDERICK P. HENRY reported in abstract

"A CASE OF INDIGENOUS PARASITIC CHYLURIA WITH FILARIA NOCTURNA IN THE BLOOD."

[See page 775.]

DISCUSSION.

DR. TYSON said that he had had several opportunities to study chyluria, but that he had examined blood from these cases only once. This opportunity occurred in the case of a patient in the German Hospital—a sailor. He was totally unsuccessful in a midnight visit in discovering filariæ, although careful efforts were made to secure a specimen. He believes that this experience is not unusual and that it is admitted that chyluria may occur in the absence of this parasite. Nor does it seem necessary, as all that is required is some obstruction of the lymph-vessels, and anything that does this suffices. One of the most interesting features in connection with the subject is that, in the case of the filaria nocturna, if the patient sleeps in the daytime, the filaria comes to the superficial vessels at that time; so that it seems after all to have nothing to do with night, but that the condition of sleep favors its presence. Therefore, the terms, *diurna* and *nocturna*, are, in a sense, not precisely correct. A term representing that the filaria has something to do with sleep, rather than night, would be more correct. Its presence in the superficial vessels seems to be due to some relaxed condition of the vessels, as the result of which their diameter is increased; At other times, the superficial vessels being contracted, the parasite is compelled to keep to the larger deep-seated vessels.

DR. STENGEL said that on examining the blood of Dr. Henry's case, he was particularly impressed by the fewness of the parasites; and he felt that they might easily be overlooked. The examination recalled to his mind a case in the practice of the President, which he examined a year or more before. This was an instance of chyluria, but the parasites were not found after careful search of a number of preparations of the blood and several specimens of the urine. Dr. Stengel had no doubt it was non-parasitic, but he could not but remark on

the ease with which one might overlook the filariæ, in the light of what he had learned from Dr. Henry's case.

DR. WILSON stated that in the case referred to by Dr. Stengel repeated examinations of the blood yielded negative results. The patient, a young girl, was a native of Pennsylvania, and had never travelled beyond the borders of the State. The chylous urine ceased to be severe and she made a satisfactory recovery.

DR. C. D. SPIVAK presented a
"CASE OF INTRA-UTERINE AMPUTATION OF THE HAND."

He stated that the left hand was absent; the distal extremities of the radius and ulna could be felt, and were freely movable. There was a wart-like projection over the radial extremity which reminded one of a rudimentary finger. The mother of the child was subject to epileptiform attacks. She had had fourteen living children, all of whom, except two, died in the first and third days from convulsions. Besides these births, she had also aborted six times. This last birth was normal but the labor was tedious.

DR. MANN asked whether or not the member that was amputated was found at the birth of the child. These cases may be due to a defect in development, to traumatism, or the pressure of a band across the amputated part. This case, from the short view he had, looked like one of defective development. If the hand was expelled, then, of course, it would be due to some other cause.

DR. SPIVAK replied that nothing at all was found.

DR. J. M. ANDERS presented a communication entitled

"TYPHOID FEVER AS A COMPLICATION AND SEQUEL OF INFLUENZA."

[See page 782.]

DISCUSSION.

DR. J. C. WILSON said that the paper was interesting as bearing upon certain facts relating both to influenza and enteric fever. He did not recall the two cases published by Dr. Anders in the previous communication upon the subject, but in the notes that were read of the cases it was very evident that influenza occurred as an intercurrent infection during the period of incubation of enteric fever. The latter is a fever of comparatively long incubation, ranging about two weeks or two and one-half weeks. The period of incubation of influenza is very brief, ranging from a few hours to a day or two. The whole course of the attack of influenza would appear to have

exhausted itself prior to the appearance of the evidences of enteric fever. It is very interesting, indeed, that the subject should have been presented in this way. Dr. Wilson did not think that we can concur in the assumption of Dr. Anders from these cases, that influenza acts as a predisposing influence to enteric fever, because in the cases referred to influenza developed and ran its course during the period of incubation of enteric fever. In a community such as Philadelphia, in which we have annually four or five thousand cases of enteric fever, there must, during a pandemic of influenza, be very frequently instances of double infection, and this double infection will explain many of the cases of enteric fever that appear to begin abruptly with shivering, headache, and pains in the bones, which mark the onset of many of the infections, but not that of enteric fever. The Society is much indebted to Professor Anders for the presentation of the cases and his suggestive remarks with them, but the coincidence of the two diseases in the same individual does not prove that one predisposes to the other.

DR. COHEN said that the paper and the subject are both extremely interesting. He once thought that it was well known and commonly taught that typhoid fever might appear during the course of influenza, or during convalescence therefrom, or that during the course of convalescence from typhoid fever symptoms of influenza might appear; and in a paper published in 1887, in the *MEDICAL AND SURGICAL REPORTER*, he had referred to these occurrences as being within his own experience. He fully agreed with Dr. Wilson that the paper and the cases do not bear out the assumption that influenza and typhoid fever may be properly referred to as complicating conditions or one as being a sequel to the other, except in the matter of time; that is to say they occur together or in sequence without any essential or necessary etiologic or pathologic connection. Referring to details, Dr. Cohen recalled attention to the frequency of hemorrhage, as noted in the paper. Hemorrhage, especially from the nose, is a common feature of influenza. Hemorrhage from the bowel may likewise occur in influenza, and is one of the factors causing influenza to be mistakenly reported as typhoid fever. When typhoid fever occurs after influenza has developed, or when influenza attacks a patient in the course of typhoid fever the tendency to intestinal hemorrhage will be exaggerated. As in his own experience the number and the gravity of cases of this accident in enteric fever have been greater since the influenza pandemic of 1889 than before, he was inclined to attribute this in some measure to the lingering "influence" of influenza which does not always manifest itself frankly or is obscured by the predominating symptoms of enteric fever, but which, nevertheless, tends to increase the frequency and severity of intestinal hemorrhage. Dr. Cohen could not look upon this complication as a mere coincidence. The

irregular fever and the violent headache and muscular pains, so much more frequent in enteric fever during recent years, may be attributed to the same cause; and Dr. Anders has done the profession a service in thus prominently calling attention to the association of influenza and typhoid fever.

DR. G. G. DAVIS exhibited

"A NEW NEEDLE-HOLDER."

Desiring a needle-holder for Hagedorn and other needles, that was less clumsy and less complicated than the ordinary forms, the following was devised: It consists of three pieces, the two blades and a connecting rod or lever. The lower blade is stiff and rigid throughout; the upper blade bends when pressure is made. When the handles are closed, the lower blade is pushed forward by means of the connecting lever. To take the holder apart, the button on the under side of the upper blade is turned with the fingers and the lever allowed to drop. The under blade and lever are then slid out of the upper blade. To separate the lever, it should be raised at right angles to the blade and unhooked. If a catch is desired, one is formed by continuing the lever down across the opposite handle. Personally, I dislike a catch and do not use it. Some of the advantages of the instrument are the small size of the jaws; the fewness of its parts—three; and the ease with which it can be taken apart for cleansing.

Menthol may prove Specific for the vomiting of pregnancy. According to Dr. Weill, in the *Practitioner*, every form of vomiting during gestation can be relieved by a twenty per cent. solution of menthol in olive oil; dose, ten drops on sugar whenever nausea appears.

An Unusual Termination for a Malpractice suit was enjoyed recently by Dr. W. O. Henry, of Omaha, Neb. He sued a patient for the amount of his bill and was in turn sued by the man for malpractice, damages being set at \$8,000. Not only was the doctor victorious in disproving malpractice, but he convinced the plaintiff and his attorney of the justice of his cause, and the former went out and borrowed \$345, with which to pay what he owed for medical services, to save which he had instituted the malpractice suit.

Vinegar is an Antidote to Carbolic Acid, according to Prof. Carleton. Applied to the skin or mucous membrane burnt by carbolic, it causes a rapid disappearance of the characteristic whiteness, as well as the anesthesia produced by carbolic, and it also prevents the formation of a slough. It also neutralizes any carbolic that may have been introduced into the stomach. The first thing, therefore, to do in cases where carbolic has been swallowed is to make the patient drink some vinegar mixed with equal parts of water, and then to wash out the stomach.

PERISCOPE.

MEDICINE.

Formulæ.

To relieve the thirst of diabetics :

Pilocarpin nitrat	gr. ss
Spirit vini dilut.	gtt. xx
Aquæ	3i

M. Sig.: The tongue is to be moistened with five or six drops of this solution four or five times daily.—*Nouv. Remedies*.

To prevent iodism :

Potassii iodidi	3iss
Ferri et ammonii citratis	3ii
Tinct. nucis vomicæ	3ii
Aquæ	3iss
Tinct. cinchonæ comp	3ii

S.: Teaspoonful three times daily, in water, after meals.—*Med. Weekly*.

To remove warts :

Hydrarg. bichlor	gr. v
Acid salicyl.	3i
Collodion	3i

M. Sig.: Apply once a day, removing the crust each time before a fresh application is made.

If necessary, the mercuric chloride may be increased to thirty grains in the same amount of collodion.—*Indian Lancet*.

To gradually remove corns :

Acid salicylici	gr. xxx
Ex. cannabis ind.,	gr. x
Colloidi	f3iv

M. Sig.: Paint on night and morning.—*Stetwagon*.

For local treatment of baldness the following is recommended :

Tinct. cantharidis	f3iv
Tinct. capsici	f3j
Ol. ricini	f3ss-f3j
Alcoholia	q. s. ad. f3iv

M. Sig.: Rub thoroughly into the scalp.—*Stetwagon*.

For migraine :

Citrate caffeine	gr. xx
Phenacetine	3jss
White sugar	gr. xv

M. Ft. capsules No. x.

Sig.: One every three to four hours during the period of the attack.—*Gazetta Medica di Roma*.

For chronic diarrhœa and dysentery :

Cupri sulph.	gr. i
Morph. sulph.	gr. i
Quin. sulph.	gr. xxiv

M. Ft. pil. No. xii.

Sig.: One three times daily.—*Medical Record*.

For erysipelas :

Ac. tannic	3ss
Camphoræ	gr. xv
Etheris	3i

S. Paint every hour or two over affected part and adjacent skin.—*New York Medical Journal*.

For chronic eczema :

Sig. carbon. deterg	3ss
Hydrarg. ammoniat	3i
Ung. zinci ox.	3ss
Vaselini	3ss

M. Sig.: Apply topically.—*Practitioner*.

For piles :

Picis ligni	gtt. xv
Ext. bellad	3ss
Glycerini	3ij

Rev. de Ther. Med. Chir.

For pruritus from jaundice :

Ichthyol	10
Spts. vini rect. dil.	40
Etheris	40

Sig.: Local application for itching.—*Medical Times and Register*.

For migraine, cholera infantum, and general irritation of the intestinal tract. Dr. F. W. Root, *New York Medical Journal*.

Morphinæ sulphatis	grs. j.
Acidi borici	grs. viij.

M. Ft. cts. No. xvj.

Sig. Add each powder, as occasion requires, to two and a half ounces of water, and give a teaspoonful of the solution every ten minutes until the desired effect is produced.

For influenza with pleuritic symptoms. Dr. S. Solis-Cohen, *Polyclinic*.

Salol	
Terp. hydrat. aa	3j.
Strych. sulph	gr. ss.
Codeinæ	gr. j.

M. Ft. caps. No. xx.

Sig. One every three hours.

For pertussis. *Giornale, Medico del Esercito.*

R
Sol. (1:1000) hydrargyri perchloridi, ʒij.
Sig. Paint the throat every morning.

For acid fermentative dyspepsia in children.
Dr. J. Madison Taylor.

R
Sodii bicarb. ʒi.
Tr. Gentian. ʒj.
Aque cinnamomi q. s. ad. ʒiv.

M. Sig. Teaspoonful as required.

For incontinence of urine. Dr. W. B. Erdman, *Medical Council.*

R
Ergotin gr. vi.
Strych. sulph. gr. 1-16.
Ext. bellad. gr. 1-5.

M. Fit pil. No. xii.

Sig. One before dinner, one before supper, and one on retiring.

For piles. Keep the parts perfectly clean and apply well into rectum. Dr. J. D. Peters, *Chicago Medical Times.*

R
Bismuthi subnit. ʒss.
Oleum ricini ʒij.

M. Ft. ung.

For chapped hands. *Kansas City Medical Record.*

R
Menthol 0 | 75.
Salol 1 | 5.
Ol. olive 1 | 5.
Lanolin 45 | 0.

Apply once or twice a day.

THE MOUNTAIN CHAUTAUQUA, Mountain Lake Park, Md., on the Main Line of the Picturesque B. & O.

The most superb and sensible summer resort in America. \$300,000 expended in improvements; 200 beautiful cottages; hotel and cottage board at from \$5.00 to \$12.00 per week—cheaper than staying at home. The mountain air and the mountain views simply indescribable. Session August 5th to the 25th. Three superb entertainments daily. The best music and the best lectures which money can procure. Dr. T. DeWitt Talmage, Gen. John B. Gordon and Bishop J. H. Vincent already secured, with 100 others. Dr. W. L. Davidson, the great Chautauqua manager, in charge.

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OPHTHALMOLOGY.

An Ideal Non-Irritating Salve is claimed by Dr. W. Allan Johnson, (*Brit. Jour. Derm.*, April, 1896) to be made by the following process:

R
Lanolini ʒij.
Ol amygdala ʒss.
Aq. dest. aa ʒss.

M.

If smeared thinly on the lids this occasions no unpleasantness, and it may be employed when it is desirable to use a salve to prevent the lids from being glued together from any increase of the lachrymal secretions. It is, however, better to add a grain or so of boric acid to prevent any possible rancidity, though this is not likely to happen even though the ointment be kept for some time. In eczema of the lips this salve forms a pleasing vehicle for the yellow oxide of mercury so beneficial in those cases, two grains being added to the half-ounce. According to the testimony of patients, the salve gives a pleasing sensation of coolness without a trace of smarting or irritation. Its curative influence, the author says is equal, if not superior, to that of any of the other eye-salves prepared with other bases.

NEWS AND MISCELLANY.

In Cases Where Parties Proposing marriage are epileptic Judge Ferris, of Cincinnati, has announced that he will not issue a marriage license and from this premise an exchange argues the advisability of general state laws forbidding the marriages of epileptics, paranoiacs, habitual inebriates, and the defective of all classes.

Officers Elected at the Annual Meeting of the American Orthopedic Association held at Buffalo, May 19th, 20th and 21st, 1896:

Dr. Samuel Ketch, of New York, President; Dr. H. M. Sherman, of San Francisco, First Vice-President; Dr. W. R. Townsend, of New York, Second Vice-President; Dr. E. G. Brackett, of Boston, Treasurer; Dr. John Ridlon, of Chicago, Secretary.

The Causes for Sterility in the Female are enumerated as follows by Graefe, *Centralblatt für Gynäkologie*: "Anomalies of the hymen or malformation of the genital tract,—a very large vagina can also be the cause of sterility, as the sperm flows out immediately after coitus; vaginismus; excessive acid reaction of the vaginal mucus, which destroys the power of motion in the spermatozoa; narrow external or internal os, ante-flexion, retro-flexion, endometritis, gonorrhoea (especially with involvement of the adnexa), neoplasms; constitutional diseases, as tuberculosis, syphilis, chlorosis, and obesity.

For the Relief of Vague Pains localized at different points upon the surface of the body, as well as in the treatment of intercostal neuralgia and the pleuritic stitches of chronic pulmonary tuberculosis, the *Medical Standard* recommends the application with a camel's hair pencil, of a mixture of equal parts of menthol chloral hydrate, and camphor, once daily, or as symptoms may indicate. Liquefaction of the solid ingredients of the prescription takes place when they are brought in contact. The resulting fluid is slightly stimulating, slightly irritant, and decidedly analgesic. Should its too frequent application result in vesication, its use should be intermitted until the parts heal.

Citric Acid is a Parasiticide, and gonococci cannot exist in an acid medium, says Pellissier, in *Aerztliche Praktiker*. He employs it in one per cent. solution for injection into the anterior urethra six times daily, or by irrigation in the strength of eight to one thousand in both anterior and posterior urethra. Fifteen cases have been successfully treated without complications and with little or no pain or irritation.

Reduced Rates to Chicago.

Account of the Democratic National Convention, Chicago, Ill., the B. & O. R. R. will sell excursion tickets from all Ticket Stations on its lines east of the Ohio River, for all trains July 3, 4, 5 and 6, good for return passage until July 12 inclusive, at one single fare for the round trip.

Tickets will, also, be sold by all connecting lines.

The B. & O. maintains a double daily service of fast vestibuled express trains, with Pullman Sleeping and Dining Cars attached, running through to Chicago solid without change or transfer.—6-20-3-t.

Poisoning by Food is Unquestionably a much more common cause of illness than is generally supposed. Bowel and intestinal disturbances are usually attributed to the weather, to taking cold, to some epidemic influence, to almost any cause but the right one. Cheese, sausage, game, oysters, mince pie, pickles, and similar foods are very likely to produce stomach and intestinal disturbance, and it is a marvel that any one can at any time eat such unwholesome foods without suffering seriously in consequence. It is only because the healthy stomach is possessed of remarkable disinfecting powers, that such abuse of the digestive organs is possible. If the stomach is overtaxed, however, its disinfecting power is lessened, and the germs taken in with the food rapidly grow, developing poisons, nausea, griping, diarrhea, and various other symptoms as the natural result. Milk is probably a more frequent cause of stomach and bowel disturbance than any other food.

Of specimens of milk recently examined, a small tablespoonful of one contained more than one and a fourth million germs. Another specimen of milk examined on the same day contained but very few germs. The difference was due simply to the difference in the care taken in obtaining the milk from the cow, and in conveying it to the creamery. The milk in the one case contained a thousand times as many germs as in the other, an indication that one of the milkmen must have been guilty of the grossest carelessness. Some of these germs were those capable of producing poisons of a highly dangerous character. Poisons developed from foods sometimes give rise to symptoms which closely resemble various diseases, such as typhoid fever, scarlet fever, pneumonia, cholera, and even metallic poisoning.—*Exchange*.

In Scarlet Fever, Veratrum Viride is claimed by Dr. R. E. Chambers, in the *Columbus Medical Journal*, to have always given good results in a practical experience of over thirty years. He says it will not disappoint him in cases free from such complications as failure of the kidneys to secrete, pulmonary edema, etc. Furthermore, these complications will not occur if the case is seen and treatment begun early. As proof of the usefulness of the drug in this disease, he cites an instance in which he was called to a family of eight children, all ill with a severe type of scarlet fever—circulation rapid, fever high, throats intensely swollen and offensive. Giving a most unfavorable prognosis, he began giving Norwood's tincture veratrum viride without ether; using one drop of the veratrum for each year of age of child, with three times the amount of ether. This medication was continued every hour, until vomiting was produced; then discontinued until fever should be manifest, then every three hours until vomiting should occur again. A solution of chlorate of potash was used in their throats, also free sponging externally. This treatment was followed out, and in a few days the cases were convalescent.

Reduced Rates to Washington.

The Young People's Society of Christian Endeavor will hold their Annual Meeting in Washington, D. C., July 7th to 13th.

For this occasion the B. & O. R. R. Co. will sell tickets, from all points on its lines, East of the Ohio River to Washington, at one single fare for the round trip, July 6th to 8th, inclusive, valid for return passage until July 15th, inclusive, with the privilege of an additional extension until July 31st by depositing tickets with Joint Agent at Washington.

Tickets will also be on sale at stations of all connecting lines.

Delegates should not lose sight of the fact that all B. & O. trains run via Washington.—8-t.